

Washington State – Integrated Community Mental Health Program

Section B. Access and Capacity

A Section 1915(b) waiver program serves to improve an enrollee's access to quality medical services. A waiver must assure that services provided are of adequate amount, are provided within reasonable time frames, and are furnished within a reasonable distance from the residence of the enrollees in the program. Furthermore, the proposed waiver program must not substantially impair access to services and access to emergency and family planning services must not be restricted.

I. Access Standards

Previous Waiver Period

a. ____ During the last waiver period, the access standards of the program were operated differently than described in the waiver governing that period. The differences were:

Upcoming Waiver Period – For items a. through c. of this section, please identify any responses that reflect a change in program from the previous waiver submittal(s) by placing two asterisks (i.e., "**") after your response. Please describe the State's availability standards for the upcoming waiver period.

a. **Availability Standards:** The State has established maximum distance and/or travel time requirements, given clients normal means of transportation, for MCO/PHP enrollees' access to the following. Check any that apply (1-9). For each item checked, please describe the standard and answer monitoring questions 10, 11 and 12.

1. ____ PCPs (please describe your standard):

2. ____ Specialists (please describe your standard):

3. ____ Ancillary providers (please describe your standard):

4. ____ Pharmacies (please describe your standard):

5. ____ *Community psychiatric inpatient Hospitals* (please describe your standard):

6. X Mental Health (please describe your standard):

** In this waiver renewal period, the state has identified travel time and contact time in their contracts with the Regional Support Networks. While it is still the belief that consumers should be seen in the place of their choice for community support services, the state recognizes that at times they must travel to community support services. When this occurs the following standards are in place:

Washington State – Integrated Community Mental Health Program

- ✓ in rural areas a 30 minute drive time
- ✓ in large rural areas a 90 minute drive time
- ✓ in urban areas, accessible by public transportation.

The exceptions to these standards identified in the contract are if a consumer chooses to seek services from a community mental health center that is farther than the drive time or there are hazardous road conditions, road construction, public transportation shortages, ferry or bus delay etc.

7.____ Substance Abuse Treatment Providers (please describe your standard):

8.____ Dental (please describe your standard):

9.____ Other providers (please describe your standard):

10. Please explain how often and how the State monitors compliance and what incentives/sanctions/enforcement the State makes with each of the standards described above.

As these are new standards, they will be monitored by random sample by the on-site monitoring teams, by tracking the number and locations of satellite sites, and by monitoring complaints and/or grievances regarding travel and access issues.

11. Please explain how the distance and travel time to obtain services under the waiver will not be further or longer than prior to the waiver.

These are being implemented for the first time under this waiver.

12. Please explain how the MCOs/PHPs will be required to ~~enable~~ *support* enrollees to access providers *and services*.

In a rehabilitation and recovery model it is best to have services occur close to where the enrollee lives, and service locations are safe and convenient for the enrollee. The majority of services should occur outside of the formal provider facilities in more natural community settings. As part of utilization management, the RSNs will be required to monitor barriers to services, to address those barriers, and to implement change. For those barriers that are beyond local control, RSNs are to report those to the state for possible intervention. Transportation and travel will be among those barriers monitored by the RSN.

b. Appointment Scheduling (Appointment scheduling means the time before an enrollee can acquire an appointment with his or her provider for both urgent and routine visits.) The State has established standards for appointment scheduling for MCO/PHP enrollee's access to the following. Check any that apply (1-9). For each item checked, please describe the standard and answer monitoring questions 10 and 11.

Washington State – Integrated Community Mental Health Program

- 1.____ PCPs (please describe your standard):
- 2.____ Specialists (please describe your standard):
- 3.____ Ancillary providers (please describe your standard):
- 4.____ Pharmacies (please describe your standard):
- 5.____ Hospitals (please describe your standard):
- 6.___x___ Mental Health (please describe your standard):

****Contact will occur within 2 hours in Emergent situations, 24 hours in Urgent situations and appointments for routine care will occur within 10 days with no more than 14 calendar days to their first appointment.**

The following are the contract definitions:

Emergent Care: Services provided for a person, that, if not provided, would likely result in the need for emergency crisis intervention or hospital evaluation due to concerns of potential danger to self, others, or grave disability according to RCW 71.05.

Urgent Care: To be provided to persons approaching a mental health crisis. If services are not received within 24 hours of the request, the person's situation is likely to deteriorate to the point that emergent care is necessary.

Routine Care: A setting where evaluation from service delivery services is provided to consumers on a regular basis. These services are intended to stabilize, sustain, and facilitate consumer recovery within his or her living situation.

- 7.____ Substance Abuse Treatment Providers (please describe your standard):
- 8.____ Dental (please describe your standard):
- 9.____ Other providers (please describe your standard):

10. Please explain how often and how the State monitors compliance and what incentives/sanctions/enforcement the State makes with each of the appointment scheduling standards checked above.

These are being implemented for the first time under this waiver. Compliance will be monitored through annual chart review, complaints and grievance and as part of the consumer satisfaction survey.

11. Please explain how often and how the State assures that appointment scheduling time frames are not longer than the non-waiver appointment scheduling.

Washington State – Integrated Community Mental Health Program

The entire Medicaid population is enrolled in the PHP.

c. In-Office Waiting Times: The State has established standards for in-office waiting times for MCO/PHP enrollee's access to the following. Check any that apply (1-9). For each item checked, please describe the standard and answer monitoring questions 10 and 11.

- 1. ___ PCPs (please describe your standard):
- 2. ___ Specialists (please describe your standard):
- 3. ___ Ancillary providers (please describe your standard):
- 4. ___ Pharmacies (please describe your standard):
- 5. ___ Hospitals (please describe your standard):
- 6. X Mental Health (please describe your standard):

For those services that do occur in the office the wait time for a consumer should be minimal. There are times when it may be necessary and acceptable for a consumer to wait however, a consumer should not have to wait for over an hour.

- 7. ___ Substance Abuse Treatment Providers (please describe your standard):
- 8. ___ Dental (please describe your standard):
- 9. ___ Other providers (please describe your standard):
- 10. ___ Please explain how often and how the State monitors compliance and what incentives/sanctions/enforcement the State makes with each of the in-office waiting time standards checked above.

These standards are being implemented for the first time under this waiver. They will be monitored by random sample of the sign-in sheets by the on-site team.

- 11. Please explain how the State assures that in-office waiting times are not longer than the non-waiver in-office waiting times.

The entire Medicaid population is enrolled in the PHP system.

II. Access and Availability Monitoring: Enrollee access to care will be monitored as part of each MCO/PHP's Internal Quality Assurance Plan (QAP), annual external quality review (EQR), periodic medical audits, or Independent Assessments (IA).

Washington State – Integrated Community Mental Health Program

Previous Waiver Period

a. x During the last waiver period, the access and availability monitoring was operated differently than described in the waiver governing that period. The differences were:

The MHD reorganized to provide more integrated activities and duties with regards to monitoring. The three sections called out in our previous waiver renewal, licensing and certification, contract monitoring, and the integrated review team were combined into one unit called Quality Assurance and Improvement (QA & I).

b. x [Required for all elements checked in the previous waiver submittal]
Please include the results from monitoring MCO/PHP access and availability in the previous two year period. [item B.II in the 1999 initial preprint; items B.4, 5, and 6 in the 1995 preprint].

As stated above, several of the access standards are new and have not been formally monitored. They will be monitored by random sample over this waiver period. Nearly all the RSNs have developed, monitored, and implemented local standards for accessing services. QA & I staff do monitor for wait list and monitor the RSN standards. They found that, for the most part, the community mental health centers were meeting the RSN standards, and, if not, the RSN had done one of two things. If this was a set standard for a long period of time corrective action was begun. If it was a standard just being developed, there was discussion of barriers and solutions worked out between the RSN and the provider(s). While there remains a need in some areas to continue to improve access to services, there have been numerous efforts by the RSNs and their service provider networks during the last two years to both monitor and enhance timely service access. Before the MHD called out the standards, staff met with each RSN individually to gather information and understand current RSN standards.

There are many examples throughout the system where Quality Review Teams (QRT) have called out areas for improvement in access to services, which have been implemented by the RSNs. For example:

In one RSN, through surveys for crisis plans and treatment, the QRT helped clinical oversight develop action steps for resolution. In another, QRT expressed concern over a particular agency to both the RSN and the QA & I team. They were able to advocate for examination of the agency and the RSN took appropriate action. In yet another RSN out of seven recommendations made to the RSN by the QRT four have been adopted.

One rural eastern Washington RSN, the QRT has requested and received RSN and its provider network's quality management plan and reports. The QRT is then presenting a report to the RSN Governing Board on status continue to monitor the implementation on the quality management plans through the next contract cycle.

Washington State – Integrated Community Mental Health Program

CMS has received copies of the monitoring reports of the QA & I unit and the annual reports of the RSNs under special terms and conditions #2 & 4 and of the grievances and complaints under special term and condition #5.

Upcoming Waiver Period – For items a. through o. of this section, please identify any responses that reflect a change in program from the previous waiver submittal(s) by placing two asterisks (i.e., "**") after your response. Check below any of the following (a-o) that the State will also utilize to monitor access:

- a. ☒ Measurement of access to services during and after a MCO/PHP's regular office hours to assure 24 hour accessibility, 7 days a week (e.g., PCPs' 24-hour accessibility will be monitored through random calls to ~~PCPs~~ providers during regular and after office hours)
- b. ☒ Determination of enrollee knowledge on the use of managed care programs
- c. ☒ Ensures that services are provided in a culturally competent manner to all enrollees.
- d. ☐ Review of access to emergency *mental health services* ~~or family planning services~~ without prior authorization
- e. ☒ Review of denials of referral requests
- f. ☐ Review of the number and/or frequency of visits to emergency rooms, non-authorized visits to specialists, etc., for medical care.
- g. ☒ Periodic enrollee ~~experience-satisfaction~~ surveys (which includes questions concerning the enrollees' access to all services covered under the waiver) will be to a sample of enrollees. Corrective actions taken on deficiencies found are also planned.
- h. ☒ Measurement of enrollee requests for disenrollment from a MCO/PHP due to access issues
- i. ☒ Tracking of complaints/grievances concerning access issues
- j. ☐ Geographic Mapping detailing the provider network against beneficiary locations will be used to evaluation network adequacy. (Please explain)

Several of the RSNs use zip code tracking as a way to monitor hospital usage, in the location of PCPs and in the establishment of service sites.

Washington State – Integrated Community Mental Health Program

k. _____ Monitoring access to prescriptions on the State Plan Formulary, Durable Medical Equipment, and therapies.

l. ☒ During monitoring, the State will look for the following indications of access problems.

1. ☒ Long waiting periods to obtain services from a PCP.
2. ☒ Denial of referral requests when enrollees believe referrals to *mental health* specialists are medically necessary.
3. ☒ Confusion about how to obtain services not covered under the waiver.
4. ☒ Lack of access to services after PCP's regular office hours.
5. _____ Inappropriate visits to emergency rooms, ~~non-authorized visits to specialists, etc., for medical care.~~
6. ☒ Lack of access to emergency ~~or family planning~~ services.
7. ☒ Frequent enrollee requests to change a specific PCP.
8. ☒ Other indications (please describe):

All elements that relate to public mental health may be included on a random sample basis during annual on-site visits. The MHD may also use the QRT and the RSNs monitoring and follow-up of these items and only review the results.

m. ☒ Monitoring the provision ~~and payment for~~ of transportation for beneficiaries to get to their outpatient, medically necessary *mental health* services.

n. ☒ Monitoring the provider network showing that there will be providers within the distance/travel times standards.

o. _____ Other (please explain):

III. Capacity Standards

Previous Waiver Period

a. _____ During the last waiver period, the capacity standards were operated differently than described in the waiver governing that period. The differences were:

In August 2000, Pierce County RSN purchased Puget Sound Hospital in Tacoma and has subsequently converted that facility into a freestanding psychiatric hospital and chemical dependency program. The Crisis Triage Center formerly located in a separate building will relocate to the hospital building in 2001. The goal is to insure capacity for comprehensive services for clients with acute needs..

b. ☒ [Required] MCO/PHP Capacity Standards. The State ensured that the number of providers under the waiver remained approximately the same or increased compared to the number before the implementation of the waiver. Please describe the results of this monitoring.

The MHD is the licensor of community mental health centers and certifies beds for

Washington State – Integrated Community Mental Health Program

involuntary treatment. The number of community mental health centers providing services has remained fairly consistent throughout the waiver. There have been some mergers or sales in the system but this has not reduced capacity.

King County RSN has proposed to establish a network of psychiatric inpatient hospital providers. As of this writing, they project implementation of their provider network by late 2001. MHD will review their written plan upon submission for approval.

Since the last waiver renewal, the state has lost community psychiatric inpatient hospital capacity. One unit has closed completely; two others have reduced available beds. A specialty hospital program for eating disorders also closed. Other hospitals are operating under severe financial strain with the prospect of closure looming. Hospitals have been confronting fiscal realities of marginal reimbursement rates, severe staffing shortages, physician shortages to serve Medicaid enrollees, and increased regulations.

The reduction in the general community psychiatric inpatient beds has had impact upon the immediate availability of beds at times resulting in consumers being placed far from their homes. The overall impact of the loss of community psychiatric hospital beds is difficult to assess at this early date. The elimination of the only specialized eating disorder program in the state has resulted in the use of out-of-state specialty services, purchased by the RSNs. The MHD and the RSNs will carefully be watching capacity.

To help offset this crisis, the Washington State legislature has authorized a small state budget proviso during 2000 and 2001 with the desire to maintain this capacity.

A group of hospital providers who provide psychiatric inpatient services have formed an association in an effort to assure that their service integrate with state and regional systems of care, and to improve the collaborative relationship with the state and regional Medicaid authorities. The MHD and the RSNs are working with this group to gather hard data about capacity needs, strategize about the development of additional and/or alternative resources.

c. x [Required if elements III.a.1 and III.a.2 were marked in the previous waiver submittal] The State has monitored to ensure that enrollment limits and open panels were adequate and that provider capacity remained approximately the same or improved under the waiver. Please describe the results of this monitoring.

The RSNs must ensure the capacity to serve the entire Medicaid population in their service area that have a medically necessary need for mental health services in the public mental health system. The RSNs are responsible for the resource and utilization management of the system. Both the revised WAC and the 01-03 contract with the RSNs have strengthened the MHD's expectation for resource and utilization management activities. The QA & I on-site team does look annually at the utilization and resource management activities of the RSNs before site visits occur.

Washington State – Integrated Community Mental Health Program

Upcoming Waiver Period -- For items a. through c. of this section, please identify any responses that reflect a change in program from the previous waiver submittal(s) by placing two asterisks (i.e., "**") after your response. Please describe the capacity standards for the upcoming two-year period.

a. MCO/PHP Capacity Standards

1.x_ The State has set enrollment limits for the MCO/PHPs. Please describe a) the enrollment limits and how each is determined and b) a description of how often and through what means the limits are monitored and changed.

All Medicaid eligible are enrolled in the PHPs.

2.____ The State monitors to ensure that there are adequate open panels within the MCO/PHP. Please describe how often and how the monitoring takes place.

3.x_ [Required] The State ensures that the number of providers under the waiver is expected to remain approximately the same or increase compared to the number before the implementation of the waiver. Please describe how the State will ensure that provider capacity will remain approximately the same or improve under the waiver.

The MHD requires written assurance from the RSNs of a sufficient number, mix, and geographic distribution of providers to meet: a) an appropriate range of services, including preventative care (e.g. EPSDT screening), case management, and specialty services; b) the needs of the anticipated number of enrollees; c) access and travel standards. The RSNs must also assure they can adjust the capacity to meet the needs of enrollees as they shift within the service area. Changes in the number, mix, and/or geographic distribution of providers must be submitted to the MHD.

4. [Required] For all provider types in the program, list in the chart below for each geographic area(s) applicable to your State, the number of providers before the waiver, during the current waiver period and the number projected for the proposed renewal period. **Please provide a definition of your geographic area**, i.e. by county, region or capitated rate area. Please complete only for the providers included in your waiver program.

The geographic area of the state is by Regional Support Network. Regional Support Networks may be one or more counties. Again, please see the map provided in Attachment Alla.

For risk-comprehensive programs, please modify to reflect your State's program and complete the following chart. *This is self-reported by the RSNs. It is consistent with what was reported under our current waiver. However, it is not comparable across the RSNs. MHD and the RSNs will work together over the fall of 2001 to come to*

Washington State – Integrated Community Mental Health Program
decision regarding reporting.

	<i>Recipient-To Provider Agency Ratio (2001)</i>	<i>Expected Change For The Renewal Period</i>
Chelan-Douglas RSN ♦		
Chelan-Douglas Behavioral Health Clinic	814:1	1,783:1
Children's Home Society	134:1	650:1
Catholic Family & Child Service	358:1	650:1
Clark County RSN		7,100:8
Columbia River Mental Health	4,764:1	
Children's Home Society	437:1	
Children's Center	1,168:1	
PeaceHealth Behavior Healthcare	355:1	
Institute of Family Development	New child agency	
Catholic Community Services	New child agency	
Family Solutions	New child agency	
Southwest Medical	101:1	
Grays Harbor RSN		
Behavioral Health Counseling	93:1	
Evergreen Counseling	2,499:1	
Greater Columbia BH RSN		
The Rogers Counseling Center	682:1	
Garfield County Services	80:1	
Columbia County Services	141:1	
CWCMH – Klickitat	465:1	
Skamania County Counseling Services	222:1	
Inland Counseling Network	910:1	
Whitman County Mental Health	461:1	
CWCMH – Yakima	5,049:1	
CWCMH – Kittitas	790:1	
Sunderland Family Treatment	1,463:1	
Lourdes Counseling Center	1,546:1	
Yakima Valley Farm Workers	1,206:1	
Catholic Family & Child Services	906:1	
Nueva Esperanza	588:1	
Lutheran Social Services	26:1	
Southeast Children's Home Society	287:1	
Crisis Response Unit	1,364:1	

♦ The 2001 figure is a point-in-time contractual figure for 1998 while the expected changes reflects an estimated unduplicated count of clients served during the '01-03 biennium.

Washington State – Integrated Community Mental Health Program

	<i>Recipient-To Provider Agency Ratio (2001)</i>	<i>Expected Change For The Renewal Period</i>
St. Mary Hospital	163:1	New provider started July 1, 2001 (Palouse Counseling)
King County RSN* '00 Outpatient Total = 29,206		
Asian Counseling and Referral Service <i>Atlantic Street Center – sub</i> <i>Auburn Youth Resources – sub</i> <i>Center for Human Services – sub</i> <i>Children's Home Society – sub</i>	808:1	
Children's Hospital & Medical Center	709:1	
Community House Residential: Spring Manor	208:1	
Community Psychiatric Clinic JAS Residential: Northlake Agape Mercer Inn Summit Inn The Inn Cascade Hall Keystone Resources El Rey Treatment Facility	2,433:1	
Consejo Counseling	715:1	
Downtown Emergency Service HOST	575:1	
Evergreen Community Health Care	742:1	
Harborview Mental Health Center CTU-HMCER	1,298:1 5,188:1	

* This is total served at each agency and includes those who are served at a subcontract agency of that organization. Total served does not include those who may be new "drop-in" or crisis services only, except at Harborview CTU. Counts at each agency and Total are unduplicated.

Washington State – Integrated Community Mental Health Program

	Recipient-To Provider Agency Ratio (2001)	Expected Change For The Renewal Period
Highline-West Seattle Mental Health Catholic Community Services- sub Kent Youth and Family – sub Lutheran Social Services – sub Northshore Youth and Family- sub Family Services of King County – sub Federal Way Youth & Family – sub Friends of Youth – sub Renton Area Youth & Family – sub Ruth Dykeman Child Center – sub Ryther Child Center – sub Residential: Highwest Residence	5,541:1	
Seattle Children's Home	515:1	
Seattle Counseling Seattle Indian Health Board – sub	259:1	
Seattle Mental Health Southeast Youth and Family – sub Southwest Youth and Family – sub Residential: Stillwater Avondale Chartley House Benson Heights	7,266:1	
Therapeutic Health Services	485:1	
Valley Cities Counseling Vashon Youth and Family – sub	2,286:1	
YMCA Youth Eastside Services – sub	93:1	
Puget Sound ESD	46:1	
SeaMar	39:1	
Muckleshoot Indian Tribe	28 children and 12 families per quarter.	
Merino Interpreting Renton Area Youth & Family – sub Ruth Dykeman Child Center – sub Ryther Child Center – sub		
Seattle Children's Home	295:1	
Seattle Counseling Seattle Indian Health Board – sub	252:1	
Seattle Mental Health Southeast Youth and Family – sub Southwest Youth and Family – sub	1,927:1	

Washington State – Integrated Community Mental Health Program

	Recipient-To Provider Agency Ratio (2001)	Expected Change For The Renewal Period
Therapeutic Health Services	274:1	
Valley Cities Counseling <i>Vashon Youth and Family – sub</i>	940:1	
YMCA <i>Youth Eastside Services – sub</i>	93:1	
Puget Sound ESD	12:1	
Muckleshoot Indian Tribe	17 children and 8 families per quarter.	
North Central WA RSN		
Grant Mental Healthcare	2,100:1	
Comm. Counseling Services of Adams County	370:1	
Okanogan Community Counseling Services	1,393:1	
Northeast WA RSN		
Stevens County	737:1	No changes anticipated
Ferry County	204:1	No changes anticipated
Lincoln County	212:1	No changes anticipated
Pend Orielle County	301:1	No changes anticipated
North Sound RSN		
		NSRSN expects slight increases due to population growth and slight increases in funding.
Catholic Community Services	490:1	
Compass Health	3,812:1	
Community Mental Health Services	1,701:1	
Whatcom Counseling and Psychiatric	1,220:1	
Seamar	260:1	
Lake Whatcom Residential Services	310:1	
Rainbow Resources	94:1	
VOA	NA (Crisis Line)	
Peninsula RSN		
Kitsap Mental Health Center	3,598:1	
Peninsula Community Mental Health Center	1,749:1	
Jefferson Mental Health Services	631:1	
West End Outreach	296:1	
Pierce County RSN		
		Average annual growth over the past 6 years has been 5.3%. We anticipate continued growth of 5-6% each year of the renewal period.
Comprehensive Mental Health	5,160:1	
Greater Lakes Mental Healthcare	5,077:1	
Good Samaritan Behavioral Healthcare	5,323:1	
Catholic Community Services	215:1	

Washington State – Integrated Community Mental Health Program

	<i>Recipient-To Provider Agency Ratio (2001)</i>	<i>Expected Change For The Renewal Period</i>
Puyallup Tribal Health Authority	510:1	
Sea Mar Community Health Center	124:1	
Southwest RSN	1,700:2	
Lower Columbia	850:1	1,050:1
Center for Behavioral Solutions	850:1	1,050:1
Spokane County RSN		Numbers based upon a 1.5% per annum increase in consumer population over the next biennium, averaged, and redistribution of # of consumers served based upon applicant agency's responses to recent RFP.
Catholic Family Services	21:1	
Children's Home Society	48:1	
Saint Luke's Rehabilitation Institute	20:1	
Spokane Mental Health	51:1	
Family Services Spokane	47:1	
Lutheran Social Services	14:1	
Sacred Heart Acute Divers.	4:1	
Native Project	13:1	
Tamarack	14:1	
Hope Partnership	18:1	
Larry Cronin	7:1	
Thurston-Mason RSN		Numbers are projected to remain the same for the biennium. Does not include crisis services.
Behavioral Health Resources	3,129:1	
South Sound Mental Health	1,117:1	
St. Peters Hospital	223:1	
Timberlands RSN		Does not include crisis services.
Cascade MH Care	1,679:1	
Willapa Counseling Center	583:1	
Wahkiakum County MH Services	91:1	

*Please note any limitations to the data in the chart above here:

For other risk programs, please modify for your State's program and complete the following chart:

Providers (Attachment BIIIa4)	# Before the Waiver	# In Current Waiver	# Expected in Renewal
Mental Health			

Washington State – Integrated Community Mental Health Program

Providers (Attachment BIIIa4)	# Before the Waiver	# In Current Waiver	# Expected in Renewal
Providers (please specify)			

I/D any major changes from the last report with explanation.

*Please note any limitations to the data in the chart above here:

b. PCP Capacity Standards

1. The State has set capacity standards for PCPs within the MCOs/PHP expressed in the following terms (In the case of a PHP, a PCP may be defined as a case manager or gatekeeper):

i. ☒ PCP to enrollee ratio

ii. ☐ Maximum PCP capacity

iii. ☐ For PCP contracts with multiple plans, please describe any efforts the State is making to monitor unduplicated Medicaid enrollment capacity across plans?

MHD's state plan approved services contain some set ratios. These are monitored by the chart reviews if the services are noted during the annual on-site monitoring or the licensing/certification reviews. The MHD has not set additional requirements.

** The MHD and their partners the RSNs may look at the grievance/complaint trends along with the PCP mix, the geographic capacity, and the exit interviews to determine the need to set additional ratios.

** The 01-03 contract with the RSNs requires them to explain, develop management plans, and/or conduct performance improvement projects to address anomalies or trends when requested by the MHD. Capacity will be one issue of focus for the MHD over the waiver period.

2. ☒ The State ensures adequate geographic distribution of PCPs within MCO/PHPs. Please explain.

Please see WAC 388-065-0345& 0405

3. ☐ The State designates the type of providers that can serve as PCPs. Please list these provider types.

c. Specialist Capacity Standards

1. ☒ The State has set capacity standards for specialty *mental health* services. Please explain.

Mental health specialists by contract must be used at critical treatment junctures. Critical

Washington State – Integrated Community Mental Health Program

treatment junctures are defined as crisis, evaluation/assessment, treatment planning, treatment review/renewal, crisis planning, placement in residential or restrictive settings, and discharge planning.

Services to underserved groups must be provided by or under the supervision of a mental health specialist. The following definitions are from the WAC.

"Mental health specialist" means:

(1) A **"child mental health specialist"** is defined as a mental health professional with the following education and experience:

(a) A minimum of one hundred actual hours (not quarter or semester hours) of special training in child development and the treatment of children and youth with serious emotional disturbance and their families; and

(b) The equivalent of one year of full-time experience in the treatment of seriously emotionally disturbed children and youth and their families under the supervision of a child mental health specialist.

(2) A **"geriatric mental health specialist"** is defined as a mental health professional who has the following education and experience:

(a) A minimum of one hundred actual hours (not quarter or semester hours) of specialized training devoted to the mental health problems and treatment of persons sixty years of age or older; and

(b) The equivalent of one year of full-time experience in the treatment of persons sixty years of age or older, under the supervision of a geriatric mental health specialist.

(3) An **"ethnic minority mental health specialist"** is defined as a mental health professional who has demonstrated cultural competence attained through major commitment, ongoing training, experience and/or specialization in serving ethnic minorities, including evidence of one year of service specializing in serving the ethnic minority group under the supervision of an ethnic minority mental health specialist; and

(a) Evidence of support from the ethnic minority community attesting to the person's commitment to that community; or

(b) A minimum of one hundred actual hours (not quarter or semester hours) of specialized training devoted to ethnic minority issues and treatment of ethnic minority consumers.

(4) A **"disability mental health specialist"** is defined as a mental health professional with special expertise in working with an identified disability group. For purposes of this chapter only, **"disabled"** means an individual with a disability other than a mental illness, including a developmental disability, serious physical handicap, or sensory impairment.

(a) If the consumer is deaf, the specialist must be a mental health professional with:

(i) Knowledge about the deaf culture and psychosocial problems faced by people who are deaf; and

(ii) Ability to communicate fluently in the preferred language system of the consumer.

(b) The specialist for consumers with developmental disabilities must be a mental health professional who:

(i) Has at least one year's experience working with people with developmental disabilities; or

(ii) Is a developmental disabilities professional as defined in RCW 71.05.020.

Washington State – Integrated Community Mental Health Program

"Mental health professional" means:

(1) A psychiatrist, psychologist, psychiatric nurse or social worker as defined in chapter 71.05 and 71.34 RCW;

(2) A person with a masters degree or further advanced degree in counseling or one of the social sciences from an accredited college or university. Such person shall have, in addition, at least two years of experience in direct treatment of persons with mental illness or emotional disturbance, such experience gained under the supervision of a mental health professional;

(3) A person who meets the waiver criteria of RCW 71.24.260, which was granted prior to 1986.

(4) A person who had an approved waiver to perform the duties of a mental health profession that was requested by the regional support network and granted by the MHD prior to July 1, 2001; or

(5) A person who has been granted a time-limited exception of the minimum requirements of a mental health professional by the MHD consistent with WAC 388-865-265.

2. X The State monitors access to specialty services. Please explain how often and how monitoring is done.

The MHD QA&I team monitors for the use of proper specialists in the annual medical audit and in the licensing and/or certification process.

3. x The State requires particular *mental health* specialist types to be included in the MCO/PHP network. Please identify these in the chart below, modifying the chart as necessary to reflect the specialists in your State's waiver. Please describe the standard if applicable, e.g. specialty to enrollee ratio. If *mental health* specialists types are not involved in the MCO/PHP network, please describe how arrangements are made for enrollees to access these services (for waiver covered services only).

Specialist Provider Type (Attachment BIIIc)				
Psychiatrist				
Other mental health providers (please specify)				

Washington State – Integrated Community Mental Health Program

Specialist Provider Type (Attachment BIIIc)				

The MHD does not set capacity standards different from those defined above. If there were increases in access or quality issues related to specialists the MHD would research the need for different requirements at the local level.

IV. Capacity Monitoring

Previous Waiver Period

a. ____ During the last waiver period, the capacity monitoring was operated differently than described in the waiver governing that period. The differences were:

b. x [Required for all elements checked in the previous waiver submittal]
Please include the results from monitoring the MCO/PHP capacity in the previous two year period [item B.IV in the 1999 initial preprint; items A.15-16 in the 1995 preprint].

The MHD on-site team monitors for delays in accessing services when they are in the provider network. The administrative team assures the RSNs are utilizing their level of care process and through utilization review monitoring and adjusting capacity appropriate to the need of the population. Level of care guidelines are set by the RSNs and approved by the MHD. The MHD also monitors RSN capacity through complaints and grievances related to access and quality services.

Upcoming Waiver Period -- For items a. through I. of this section, please identify any responses that reflect a change in program from the previous waiver submittal(s) by placing two asterisks (i.e., "**") after your response.

Please indicate which of the following activities the State employs:

a. x Periodic comparison of the number and types of Medicaid *mental health* providers before and after the waiver.

b. x Measurement of *use of mental health* specialists.

c. x Provider-to-enrollee ratios

d. x Periodic MCO/PHP reports on provider network

e. x Measurement of enrollee requests for disenrollment from a plan due to capacity issues

f. x Tracking of complaints/grievances concerning capacity issues

Washington State – Integrated Community Mental Health Program

g. _____ Geographic Mapping (please explain)

no h. in document

i. _____ Tracking of termination rates of PCPs

j. _____ Review of reasons for PCP termination

i. and j. are done at the RSN level. On a sampling basis they track both why PCPs are leaving the system and why consumers are seeking changes from one PCP to another. PCPs are defined in WAC as the person responsible to carry out the individualized service plan.

**WAC 388-865-0280 requires exit interviews of both consumers and staff be incorporated into the QM plan of the system. MHD may consider their findings to their QM Plan to help refine capacity standards. Whatever is decided it will be done with care so that consumers will not see this as a barrier to request change.

k. X _____ Consumer ~~Experience~~ *Satisfaction* Survey, including persons with special needs,

l. _____ Other (Please explain):

V. Continuity and Coordination of Care Standards

Previous Waiver Period

a. _____ During the last waiver period, the continuity and coordination of care standards were operated differently than described in the waiver governing that period. The differences were:

Upcoming Waiver Period -- For items a. through h. of this section, please identify any responses that reflect a change in program from the previous waiver submittal(s) by placing two asterisks (i.e., "**") after your response. Check any of the following that the State requires of the MCO/PHP:

a. X _____ Each enrollee selects or is assigned to a primary care provider appropriate to the enrollee's needs

b. _____ Each enrollee selects or is assigned to a designated health care practitioner who is primarily responsible for coordinating the enrollee's overall health care.

c. X _____ *Mental Health* education/promotion. Please explain.

Washington State – Integrated Community Mental Health Program

Mental health education and promotion occurs throughout the state on many levels. Education occurs through: advisory boards; cross-system working partnerships; joint support groups for persons with co-occurring disorders; the NAMI and their many affiliate groups; the use of kiosks at the malls; booths at county fairs; special community events during mental health month; bus advertisements; parent support groups, PSAs; clubhouse activity; websites; QRT and Ombuds forums; depression check lists; behavioral health conference; videos; public forums on special topics such as ADHD, healthy kids day activities; joining in with physical health on local community events; and activities in the schools.

Yearly there are many conferences, training and technical assistance opportunities sponsored by the MHD, the RSNs, and the Community Mental Health Centers that are available to providers of services, consumers and family members, allied formal systems, natural supports, informal systems, and all other interested parties.

The MHD, through its federal block grant funds, provides support to many other cross-system partners to include mental health in their conferences. To name a few, there was financial support provided to the Alzheimer's Society, the foster parent training, individualized and tailored care; FAS conference/training; co-occurring disorder conferences, Tribal events, and early intervention conference.

As mentioned earlier in the stakeholder section, the MHAC and its subcommittees are dedicating their efforts this year and next to the reduction of stigma and the promotion of best practice. They will seek innovative projects to educate law enforcement officers and community leaders on mental illness and on the mental health system. The committee also will seek nominations from across the state for best practices that show positive consumer outcomes and host a two day statewide event to share what it may take to replicated those processes in other areas of the state.

d. x Each provider maintains, for Medicaid enrollees, health records that meet the requirements established by the MCO/PHP, taking into account professional standards

Some RSNs have adopted the NCQA treatment record review guidelines. Most have set treatment record standards throughout their geographic area. Most chart to the requirements and format of the most restrictive payer (e.g., Medicare standards).

e. x There is appropriate and confidential exchange of information among providers.

f. x Informs enrollees of specific health conditions that require follow-up and, if appropriate, provides training in self-care

g. x Deals with factors that hinder enrollee compliance with prescribed treatments or regimens.

Washington State – Integrated Community Mental Health Program

h. ☒ Case management (please define your case management programs)
Case management is defined in WAC 388-865-0400; - 0456.

VI. Continuity and Coordination of Care Monitoring

Previous Waiver Period

a. ☐ During the last waiver period, the continuity and coordination of care monitoring was operated differently than described in the waiver governing that period. The differences were:

b. ☒ [Required for all elements checked in the previous waiver submittal]
Please include the results from monitoring continuity and coordination of care in the previous two year period [item B.VI in the 1999 initial preprint; Section B (as applicable) in 1995 preprint].

Cross-system collaboration is one of the three focus area for the annual medical audit and the QA & I activities. Through licensing activity there is a review of addressing a consumer's life domains including, but not limited to, housing, food, medical, dental, transportation, employment/education, and cultural. Where these domains are not addressed corrective action is begun. If a life domain is mentioned as needing assistance with no follow through activity planned there is also corrective action. When and if the gaps identified are large, the agency may be given a provisional license with a 60-day follow-up visit scheduled. During this waiver period this has occurred in six agencies. Four of these agencies have been revised and have moved to the 90% standard set by the QA & I unit. The other two community mental health centers will be revisited in the fall of 2001.

During the last two years the RSNs and their related network of providers have made significant strides in developing both formal and informal working relationships with allied systems that share and provide services to consumers utilizing multiple service systems. The monitoring team of the mental health division had made numerous recommendations to various RSNs to improve working relationships with various allied systems. Generally, the RSNs have made efforts to coordinate with these systems which has resulted in better continuity of care for consumers.

Statewide, RSNs are getting a better sense of the need for natural support involvement and cross-system involvement. There are cases where there is strong consumer and natural support involvement and those with excellent cross-system collaboration.

Another positive trend with RSNs in general is the level of functional regional (sub)committees. Most regions have active agency directors/clinical directors meeting with the RSN administration and many have regional QM committees that have a variety of provider, consumer, and allied system involvement. This past year has been the most notable in seeing strategic goals/products from these committees.

Washington State – Integrated Community Mental Health Program

The most concrete and pervasive issues that QA & I continues to identify in reviews is with strength-based, collaborative, consumers and natural support driven care and proactive crisis/risk management planning. They have seen a positive trend in treatment planning that leads the clinicians to identify strengths and supports and incorporated them into service delivery. Crisis plans have continued to improve leaning more towards risk reduction, helping the consumer and supports identify early identification and intervention at the earliest signs of decompensation. RSNs have made significant improvements in this area and have identified the concepts on their forms with that preventative philosophy in mind.

The inconsistency seen most by QA&I in the medical review is collaborative efforts between Children's Administration (CA) and Division of Developmental Disabilities. There are some regions where relations are excellent. It does appear that each of those RSNs are attempting to work with regional CA and/or DD, but are getting no response or "we don't have resources - you do, leave us alone." Interestingly the administrative portion of the review sees the relationship with CA in the last year as developing stronger and better relations. This may reflect efforts at the local administrative levels have improved collaboration but that those improvements have not yet filtered down to those performing direct care services for the various systems.

All of this monitoring activity has lead to the following contract expanded terms in our 01-03 contract to: "Develop service delivery protocols for the coordination and integration of services for consumers with multiple needs including:

- ◆ Children (including, but not limited to, Native American/Indian children and children served by DSHS Juvenile Rehabilitation Administration and Children's Administration);
- ◆ Adults and older adults served by DSHS Aging and Adult Services Administration.
- ◆ The Contractor shall include consumers, parents/foster parents, and representatives of other involved systems in the development of the protocols..."

Reports on the development of these protocols will be submitted to the MHD and should include information of barriers found to service delivery that may need to be addressed at the state level.

MHD also meets regularly with cross-system partners at the state level and through its interactions with the advisory board and the subcommittees and other meetings of stakeholders. There has been improvement in the way that the systems are described as working together (e.g. shared training, better communication) however, there is also an increasing demand on the public mental health system to see additional clients due to the growing awareness of mental illness. This becomes difficult due to the statutorily defined population we serve and the need for medically necessary services. What we are finding is that we are serving those most in need, while our cross-system partners are requesting that we see a much larger population within the limited amount of resources we have. This dynamic also played a part in the creation of the contract term for collaborative protocols and continued partnerships and educational information sharing on the mandates of the various systems across the agency.

Washington State – Integrated Community Mental Health Program

The MHD has been developing a performance measure for date of first community contact from discharge from a state or community psychiatric hospital. There have been several issues with this performance indicator from the definition of discharge to the way face-to-face contact is tracked. Another difficulty of this indicator is the “safety net” factor of the public system. The involuntary detention service is a piece of the public mental health system for the citizens of the state. When these people leave the hospitals they return to their private insurance, nursing home, etc. and not to the public system.

c._x_ [Required for all elements checked in the previous waiver submittal]
Please describe any continuity or coordination of care requirements (i.e., information sharing requirements or any efforts that the State has required to avoid duplication of services) with these entities that the State required during the previous waiver period for the entities marked in B.VI in the previous waiver submission. These requirements do not include monitoring efforts.

It has been essential since the beginning of the mental health managed care system that the RSNs establish working partnerships with each of their allied system partners to address the needs of the consumers we serve.

The RSN will maintain a demonstrated commitment to coordinate care for covered enrollees with all other relevant entities and to do so in an efficient manner to improve mental health services and allow for efficiency when delivering services to persons involved with other allied system.

Several provisions of RCW 71.24 give guidance to the coordination role of the RSNs but among those most significant to this section of the waiver renewal are those spelled out in the legislative intent Section 71.24 (15).

“(5) Coordination of services within the department, including those divisions within the department that provide services to children, between the department and the office of the superintendent of public instruction, and among state mental hospitals, county authorities, community mental health services, and other support services, which shall to the maximum extent feasible also include the families of the mentally ill, and other service providers; and

Coordination of services aimed at reducing duplication in service delivery and promoting complementary services among all entities that provide mental health services to adults and children.

It is the policy of the state to encourage the provision of a full range of treatment and rehabilitation services in the state for mental disorders. The legislature intends to encourage the development of county-based and county-managed mental health services with adequate local flexibility to assure eligible people in need of care access to the least-restrictive treatment alternative appropriate to their needs, and the availability of treatment components

Washington State – Integrated Community Mental Health Program

to assure continuity of care. To this end, counties are encouraged to enter into joint operating agreements with other counties to form regional systems of care which integrate planning, administration, and service delivery duties assigned to counties under chapters 71.05 and 71.24 RCW to consolidate administration, reduce administrative layering, and reduce administrative costs.

It is further the intent of the legislature to integrate the provision of services to provide continuity of care through all phases of treatment. To this end the legislature intends to promote active engagement with mentally ill persons and collaboration between families and service providers.”

d. x [Required for all elements checked in the previous waiver submittal if this is a PHP mental health, substance abuse, or developmentally disabled population waiver] Please describe the State's efforts during the previous waiver period to ensure that primary care providers in FFS, PCCM or MCO programs and PHP providers are educated about how to detect MH/SA problems for both children and adults and where to refer clients once the problems are identified. Please describe the requirements for coordination between FFS, PCCM, or MCO providers and PHP providers. Please describe how this issue is being addressed in the PHP program.

MHD and Medical Assistance Administration (MAA) have conducted five joint informational meetings in local areas to facilitate Healthy Options and RSN coordination. MAA is developing contract language for calendar year 02 to address coordination. MHD has developed language in the 01-03 contract to address consumer education, dispute resolution and service coordination protocols. This effort is expected to benefit consumers by clarifying eligibility and reducing confusion about whom is responsible for treatment. Washington State Medical Association is in attendance at all of the MHD/MAA joint meetings and provides the Mental Health Division a liaison to WSMA. He has brought issues back to the MHD that has led to follow-up activities in the community.

Specific training occurring with regards to the identification of mental illness varies across the state. Three large Healthy Option providers are also mental health providers; several major providers have mental health, developmental disabilities and physical care interaction weekly, the RSN and providers make psychiatrists available to the FFS physical provider to provide consultation; Regional Advisory boards educate primary care doctors on psychotropic drugs; Washington Advocates for the Mentally Ill, NAMI_WA provided training through the University of Washington to Doctor's and Nurses on mental health laws and mental illness issues; the ethnic minority specialist forum invite physical doctors and they have been asked to present a workshop. When the MHD and RSNs assumed the responsibility for community psychiatric inpatient there were many specific training events on mental health issues.

During intake, physical care is reviewed. The training for case managers offered through the WIMRIT included intake preparation/planning.

Washington State – Integrated Community Mental Health Program

MHD, MAA, and DASA are involved in a CMHS study of mental health services, substance abuse services and Medicaid payments to look at service delivery and cost patterns. Another study, being conducted at Harborview, will look at benefits of Naltrexone in treating individuals with co-occurring mental illness and substance abuse disorders. Other collaborative efforts include training for case managers on co-occurring disorders in youth and adults with both Division of Developmental Disabilities (DDD) and DASA. Studies are intended to identify best practice for multiple system consumers.

DD training- Phase 1 training included 9 training sites across the state with the targeted audience of MH and DD clinicians/administrators. The goal was to provide training in overall systems (MH-how we are structured, laws, and crisis access with a local system introduction) (DD-eligibility, programs, and access). There were 300 people trained. Phase 2 training was 10 training sites across the state with an audience of employment/vocational and residential providers. The two trainers focused on how to provide MH treatment to DD individuals and how to write and implement cross-system crisis plans. Training is averaging 60-70 people at each training. In addition, phase 2 funded a track at the Behavioral Health Conference with national speakers and presenters. DDD has received funding for phase 3 training.

Olmstead: MHD applied for and received a \$20,000 grant per year for three years to design and implement cross-system training with Aging and Adult Services Administration (AASA).

The focus will be residential providers and how to develop cross-system crisis plans with multiple steps prior to calling the crisis line. In addition, training will include local people who will talk about local systems such as when to call the crisis line and what to expect from them. In addition, through federal block grant funds, there is a small amount of funds that will also assist in providing this training.

Division of Alcohol and Substance Abuse (DASA) and MHD made a joint proposal to CSAT to acquire technical assistance funds to conduct six regional "mini-trainings" across the state for chemical dependency and mental health providers regarding the four-quadrant definition adopted by the state on co-occurring disorders, including assessment and referrals. The trainers were out of the University of Washington, Ph.D. level trainers from the ethnic minority populations; one specializes in youth, the other adult. Both trainers have chemical dependency backgrounds. There were 150 people trained.

Additional projects funded by federal block grant funds for DASA and mental health providers were the Youth Academy and Adult Academy trainings which includes participants from chemical dependency, mental health, child welfare, Department of Corrections, and Juvenile Rehabilitation Administration providers. Washington Institute of Mental Illness Research and Training (WIMIRT) in Tacoma and Spokane provided training. There were a total of eight weeklong trainings each for the youth and the adult tracks twenty-four slots per session. The focus was to reach entry-level providers.

DASA and MHD jointly funded six regional co-occurring disorder trainings to chemical dependency and mental health providers. Each Region determined their training needs

Washington State – Integrated Community Mental Health Program

through a collaborative effort between DASA, the RSN administrator and the providers. There were a total of 100 training hours of which 1,534 have been trained at 77 hours completed.

DASA sponsored a Tribal Summit meeting in March, 2001. MHD was invited to participate. DASA issues were primarily identified by Tribes. DASA plans to have a follow up meeting regarding these issues in the fall of 2001. The Tribes, in collaboration with DASA, want this to be an annual event and have invited MHD to the table. MHD will assist in the identification of systems issues with DASA and share meeting costs.

There were twelve co-occurring disorder (COD) stakeholder meetings across the state over the past biennium. A ten-point objective legislative implementation plan was completed June 30, 2001. The plan assisted in providing guidance to attain goals. Goals accomplished were (1) COD definition for treatment providers; (2) Youth COD behavioral guideline for providers; (3) legislative revision to the chemical dependency ITA law to resemble the MH ITA law; (4) legislative funding of a 35 co-occurring inpatient facility in eastern Washington; (5) funding and placement of a half-time chemical dependency provider at MHD's Child Study and Treatment Center for co-occurring disordered youth; (6) produced a report for the implementation of a "One-Stop: Integrated Eligibility Process" for folks with co-occurring disorders (this was a broad systems review that reports the 'front door' to services is wide open; once inside, however, is where consumers begin to fall through the cracks because of complicated and specific time limited funding for certain types of needed services for certain populations); (7) implemented an agreement between DASA and MHD to reduce administrative barriers for providers by providing WAC exemptions for dually certified and dually funded COD programs; (8) implemented a statewide training plan (referenced in this section's response); (9) studied the feasibility of funding additional integrated crisis response systems statewide, including alcohol/drug detoxification services, the outcome of which provided a funding ticket in excess of \$32 million and for which the state legislature stated they did not have appropriation capacity; (10) housing funding resources were identified and shared with community providers in chemical dependency and mental health programs to enhance opportunities for housing for persons with co-occurring disorders; (11) interagency agreements were in MHD's 1999-01 contract to RSN's to promote cost sharing and system efficiencies in co-occurring disorders.

The Department of Corrections is collaborating with DASA and MHD to develop coordinated services to individuals with co-occurring disorders upon release from corrections into the community.

In April 2001, DASA and MHD completed its eleventh annual, jointly funded COD Conference.

The RSNs have provider training through the NAMI meetings to cross-system partners and through various support groups. There has been RSN sponsored training to the community at large on ADHD, FAS and depression.

Washington State – Integrated Community Mental Health Program

e. x [Required if this is a PHP mental health, substance abuse, or developmentally disabled waiver] Please describe how pharmacy services prescribed to program enrollees are monitored in this waiver program. In addition, please note if pharmacy services are not covered under this program.

Pharmacy services are not covered under this waiver. Those services are provided by our sister agency the Medical Assistance Administration (MAA).

The annual medical review and the licensing review look at medication management services.

**There is a strengthened requirement in the quality management plan for 01-03 requiring each RSN to coordinate with physical health care.

Medical record sharing currently occurs with the provider network and other medical practitioners as it would when a consumer requests.

Upcoming Waiver Period – For items a. through c. of this section, please identify any responses that reflect a change in program from the previous waiver submittal(s) by placing two asterisks (i.e., "**") after your response. Please describe how standards for continuity and coordination of care will be monitored in the upcoming two year period.

a. How often and through what means does the State monitor the coordination standards checked above?

The State monitors this in many ways. Assurance of cross-system working partnerships has been a focus area of the QA&I team over the last several years. This means that along with two other areas of focus (consumer voice and quality management) more specific attention has been paid to this section of the public mental health managed care program during annual on-site visits. There have been special tools developed and questions asked that monitor this requirement. Those tools can be found in Attachment BV1a. Continuity of Care issues are also part of the chart reviews and the seamless transition between inpatient and outpatient care is monitored.

Additionally through ongoing and routine stakeholder work the MHD routinely monitors continuity of care and cross-system collaborations.

b. Specify below any providers (which are excluded from the capitated waiver) that the State explicitly requires the MCO/PHP to ~~coordinate health care services~~ *maintain working partnerships for coordinated care* ~~excluded from the capitated waiver with:~~

1. Mental Health Providers (please describe how the State ensures

Washington State – Integrated Community Mental Health Program
coordination exists):

2. x Substance Abuse Providers (please describe how the State ensures coordination exists):

3. x Local Health Departments (please describe how the State ensures coordination exists):

4. x Dental Providers (please describe how the State ensures coordination exists):

Dental Services in the state for adults and to some degree children are very limited. If a consumer of the public mental health system is in need of a dentist, efforts may be made to help them access this care. It is something that is monitored during on-site monitoring activities.

5. x Transportation Providers (please describe how the State ensures coordination exists):

MHD is actively involved to ensure coordinated transportation is available to all Medicaid consumers with Special Needs especially children by way of active participation in the Program for Agency Coordinated Transportation (PACT) forum. The forum consists of representatives from all of the state agencies that serve people who have special transportation needs. The PACT forum carries out the work plan of ACCT (Agency council on coordinated Transportation).

MHD has initiated and developed internal operating policies to address all transportation service needs for Medicaid recipients with special needs. MHD continues to monitor and ensure Medicaid consumers have transportation needs met through the exception program developed through its transportation brokers statewide. Policy is attached as Attachment BVI5)

6. x HCBS (1915c) Service (please describe how the State ensures coordination exists):

7. x Developmental Disabilities (please describe how the State ensures coordination exists):

8. x Title V Providers (please describe how the State ensures coordination exists):

Title V children are not easily identified in the public mental health system. These children who present with a serious emotional disturbance will be seen as will any other child. MHD and DOH have a data sharing agreement to track these children as a result of special terms and conditions # 3 on our waiver. MHD then sends the (encrypted) names of these children to the RSNs for the purpose of tracking grievance and fair-hearing. To date, reports show that approximately 180 children access our system that are identified strictly as Title V. This does

Washington State – Integrated Community Mental Health Program

not take into account the children that are on Title V and also SSI or foster care as they may show in that classification.

9. _____ Women, Infants and Children (WIC) program

10. x Indian Health Services providers

The MHD is aware of the study produced by the University of Washington, which reports the high rates of serious emotional disturbance among American Indian children. MHD will be closely monitoring the access and quality of the services these children receive in the public mental health system and hoping to better coordinate and engage the IHS providers. This will be a topic at the IPAC meetings over the next waiver period.

11. _____ FQHCs and RHCs not included in the program's networks

12. _____ Other (please describe):

- Tribal authorities;
- the DSHS regional office of the Division of Aging and Adult Field Services, including the regional office of Residential Care Services;
- the local AIDS Network;
- Area Agency on Aging;
- the DSHS regional office of the Children's Administration;
- state psychiatric hospitals;
- free standing evaluation and treatment facilities;
- local schools;
- local Medicaid medical managed care plans (Healthy Options, Basic Health Plan Plus)
- the DSHS Division of Vocational Rehabilitation;
- county jails and Department of Corrections;
- the DSHS Juvenile Rehabilitation Administration, and the
- county juvenile court.

Monitoring activities of these working partnerships are described throughout this document.

Washington State – Integrated Community Mental Health Program

Rating

RSN/PHP REVIEW PROTOCOL

2000

<p>9. Is there anything that you would change in the structure or activities of the Advisory Board to improve or enhance the Board's ability to be more effective?</p> <p>What are the barriers that would keep you from doing so?</p>	
<p>10. What are the Advisory Board plans for the next twelve months? Please describe the major features of this plan.</p>	
<p>11. Are there any quality improvement issues that are of an ongoing nature that we have not already discussed that you would like to share with us?</p>	
<p>12. Do you have any other thoughts or information from your perspective that you would like to share with us regarding consumer voice, cross-system collaboration or quality management relating to your region?</p>	
<p>13. Does the Advisory Board have any questions that</p>	

RATING KEY:

1 = Finding (does not meet technical requirements)

2 = Concern (only meets technical requirements not necessarily intent)

3 = Acceptable (meets intent as well as technical requirements)

4 = Exemplary (exceeds performance expectations)

B. VI A - 3

Rating

RSN/PHP REVIEW PROTOCOL

2000

[illegible]

RATING KEY:

- 1 = Finding (does not meet technical requirements)
2 = Concern (only meets technical requirements not necessarily intent)

- 3 = Acceptable (meets intent as well as technical requirements)
4 = Exemplary (exceeds performance expectations)

B. Vla-

Rating

RSN/PHP REVIEW PROTOCOL

2000

OMBUDS INTERVIEW QUESTIONS	RESPONSE
<p>1. Has there been any structural changes with regards to the Ombuds services since our last on-site review?</p>	
<p>2. Do you (the Ombuds) have adequate resources /training to provide advocacy /outreach services to the entire region (RSN/PHP)?</p> <p>What else do you need that would enable you to better do your job?</p>	
<p>3. Do you believe that there has been adequate information and materials being made available to the Medicaid enrolled individuals in all geographical areas of your region for the Ombuds services?</p> <p>What is your role in this process verses the RSNs?</p>	

RATING KEY:

- 1 = Finding (does not meet technical requirements)
- 2 = Concern (only meets technical requirements not necessarily intent)

- 3 = Acceptable (meets intent as well as technical requirements)
- 4 = Exemplary (exceeds performance expectations)

B. VIa-s

Rating

RSN/PHP REVIEW PROTOCOL

2000

<p>4. Do you meet regularly with the Advisory Board and /or Governing Board and the Quality Review Team? How would you describe these interactions and the productiveness of these meetings?</p>	
<p>5. Can you give examples of trends have you seen with regard to complaints and grievances?</p> <p>How are they being addressed?</p>	
<p>6. Do you believe that the RSN/PHP has considered any/all of your findings and reports in good faith? Give example.</p> <p>Have the service providers? Give examples.</p>	

RATING KEY:

- 1 = Finding (does not meet technical requirements)
- 2 = Concern (only meets technical requirements not necessarily intent)

- 3 = Acceptable (meets intent as well as technical requirements)
- 4 = Exemplary (exceeds performance expectations)

B. VIa-6

Rating

RSN/PHP REVIEW PROTOCOL

2000

<p>7. Since the last MIID review, to what extent have you been requested to provide outreach, case findings, or requested to assist in resolving individual complaints related to contracted services, including but not limited to:</p> <ul style="list-style-type: none"> • State hospitals? • Local hospitals? • Jails? • Shelters? <p>Any other special population within the RSN?</p> <ul style="list-style-type: none"> • sexual minorities? • ethnic minorities? • seriously emotionally disturbed children and their families? <p>What are your plans to address outreach for those areas where you have not been able to provide advocacy/outreach?</p>	<p>Federal waiver page 11 Contract exhibit D. (1)</p>
<p>8. Do you have any further comments to offer regarding consumer Voice, consumer satisfaction, Cross System Collaboration or Quality of care within this RSN/PHP?</p>	
<p>9. Does the Ombuds have any questions for the RSN that you would like us to inquire about?</p>	

RATING KEY:

- 1 = Finding (does not meet technical requirements)
2 = Concern (only meets technical requirements not necessarily intent)

- 3 = Acceptable (meets intent as well as technical requirements)
4 = Exemplary (exceeds performance expectations)

B.VIa-7

Rating

RSN/PHP REVIEW PROTOCOL

2000

10. What does the Ombuds perceive as its
Strengths-

Challenges-

Note: At this point we should be able to share what we believe to be strengths and challenges for feedback.

RATING KEY:

- 1 = Finding (does not meet technical requirements)
- 2 = Concern (only meets technical requirements not necessarily intent)

- 3 = Acceptable (meets intent as well as technical requirements)
- 4 = Exemplary (exceeds performance expectations)

B. VIa- 8

Rating

RSN/PHP REVIEW PROTOCOL

2000

QRT INTERVIEW QUESTIONS	RESPONSE
1. What if any, structural or role changes in the QRT have occurred since the MHD last review?	
2. In terms of the operation of the QRT how would you assess your <u>collective</u> ability for: Maintaining longevity of members? Maintaining interest and attendance among board members? Being able to carry out and attain goals? Effecting positive system changes that make a difference for consumers?	
3. What has been the level of your interaction as QRT members both formally and informally with the Ombuds? What can you tell us about the outcomes and/or results of this interaction? Does the QRT perceive any barriers that might impede	

RATING KEY:

1 = Finding (does not meet technical requirements)

2 = Concern (only meets technical requirements not necessarily intent)

3 = Acceptable (meets intent as well as technical requirements)

4 = Exemplary (exceeds performance expectations)

B.VIa - 9

Rating

RSN/PHP REVIEW PROTOCOL

2000

interaction with the Ombuds?	
4. Does the Contractor (RSN) act as a resource or facilitate the QRT meetings in your RSN? In what ways? Has this been upon your request?	
5. What feedback have you received as a result of distributing your quarterly reports from the following stakeholders: <ul style="list-style-type: none"> ▪ RSN Administration, ▪ Governing Board, ▪ Advisory Board, ▪ Ombudsman(s), ▪ Local consumer/family advocate groups, ▪ Services area mental health advisory boards, Provider(s)?	
6. Is the QRT able to obtain the data it needs to study and analyze systemic issues? If so, is this received in a timely manner? Examples	
7. Please discuss with us examples at various levels of the RSN/PHP where there has been positive responsiveness to your recommendations or activities. Has there been no response or negative response?	

RATING KEY:

- 1 = Finding (does not meet technical requirements)
 2 = Concern (only meets technical requirements not necessarily intent)

- 3 = Acceptable (meets intent as well as technical requirements)
 4 = Exemplary (exceeds performance expectations)

B. Vla - 10

Rating

RSN/PHP REVIEW PROTOCOL

24000

[illegible]

RATING KEY:

1 - Flooding (does not meet technical requirements)

2 = Concern (only meets technical requirements not necessarily intent)

3 = Acceptable (meets intent as well as technical requirements)

d = Exemplary (exceeds performance expectations)

$$P_3 \cdot V \mid Q = 11$$

Rating

RSN/PHP REVIEW PROTOCOL

2000

--	--

RATING KEY:

- 1 = Finding (does not meet technical requirements)
- 2 = Concern (only meets technical requirements not necessarily intent)

- 3 = Acceptable (meets intent as well as technical requirements)
- 4 = Exemplary (exceeds performance expectations)

B.VIa - 12

Rating

RSN/PHP REVIEW PROTOCOL

2000

	I. CONSUMER VOICE	
	General <i>Prior year strengths: (Advisory Board, Ombuds, QRT)</i>	
	Prior Year Quality improvements: Note: See prior year ROC report	

RATING KEY:

- 1 = Finding (does not meet technical requirements)
- 2 = Concern (only meets technical requirements not necessarily intent)

- 3 = Acceptable (meets intent as well as technical requirements)
- 4 = Exemplary (exceeds performance expectations)

B. VI A - 13

Rating

RSN/PHP REVIEW PROTOCOL

2000

Advisory Board

Prior year Strengths:

Prior year Quality Improvements:

	1. What does the Contractor perceive its strengths are in this area?	
	What does the Contractor perceive its challenges are in this area?	
	2. The RSN maintains an advisory board that is broadly representative of the demographic character of the region. What, if any, changes have occurred in the Advisory Board structure since the last integrated review? Total Membership? Number of active members?	WAC 275-57-080

RATING KEY:

- 1 = Finding (does not meet technical requirements)
- 2 = Concern (only meets technical requirements not necessarily intent)

- 3 = Acceptable (meets intent as well as technical requirements)
- 4 = Exemplary (exceeds performance expectations)

B. Via-14

Rating

RSN/PHP REVIEW PROTOCOL

2000

	3. Does the Advisory Board membership consist of at least 51% members who are consumers, past consumers, family or foster family members of consumers including parents of emotionally disturbed children, of the public mental health system.	WAC 275-57-080 (1)(b) Note: There are no specific requirements for an advisory board in the federal waiver. The Advisory Board is a requirement in WAC 275-57-080. RCW 71.24 states the RSN <u>may</u> elect to appoint an advisory board.
	4. Can the RSN provide examples on how the advisory board comments on : <ul style="list-style-type: none"> • <u>Plans?</u> • <u>Budgets?</u> • <u>Policies?</u> 	WAC 275-57-080
	5. Can the RSN provide examples on how the advisory board forwarded its comments to the RSN governance body and elected officials responsible for the mental health program for incorporation and feedback?	Federal Waiver page 21 WAC 275-57-080 (2)(b)

RATING KEY:

1 = Finding (does not meet technical requirements)

2 = Concern (only meets technical requirements not necessarily intent)

3 = Acceptable (meets intent as well as technical requirements)

4 = Exemplary (exceeds performance expectations)

B. VIa- 15

Rating

RSN/PHP REVIEW PROTOCOL

2000

Ombuds Services	
<i>Prior year strengths:</i>	
<i>Prior year Quality Improvements:</i>	
1. What does the Contractor perceive as its strength of its Ombuds services?	
What does the Contractor perceive as challenges of its Ombuds services?	

RATING KEY:

- 1 = Finding (does not meet technical requirements)
- 2 = Concern (only meets technical requirements not necessarily intent)

- 3 = Acceptable (meets intent as well as technical requirements)
- 4 = Exemplary (exceeds performance expectations)

B.VIa-16

RSN/PHP REVIEW PROTOCOL

2000

	2. What examples can the Contractor provide which would describe the Ombuds efforts to coordinate and collaborate with the regional long term care ombudsman program to reduce and avoid duplication of services for older persons with mental illness?	Exhibit D, (4)
	3. What examples can the Contractor provide which would describe the Ombuds efforts to coordinate and collaborate with the DSHS, Division of Children and Family Services Constituent Relations Office, and other stakeholders, including but not limited to other current or future Ombuds programs to ensure coordination and collaboration and reduction in duplication of services to children and adolescents with serious emotional disturbance and their families? How has the RSN made the expectation of this requirement clear for the Ombuds?	Exhibit D (4) The DSHS, Division of Children and Family Services Constituent Relations Office, is located in Olympia. 1-800-723-4831, (360)- 902-8060, Receptionist is Jodi. You can also connect with one of the Program Managers, Lynnette Shaw (360) 902-8064, or Pete Scott (360)- 902-8062.
	4. As a result of the Ombuds information gathering activities did the Contractor learn anything about: <ul style="list-style-type: none"> Physical safety (food, health, housing) Emotional safety (honest/respectful services, freedom from coercion, intimidation) Service recipient satisfaction 	Federal Waiver page 11 Exhibit D (2)
	5. What level of involvement does the Ombuds have with regards to assisting consumers who have complained or filed a grievance about access to services or requested a disenrollment?	Federal Waiver Interest

RATING KEY:

1 = Finding (does not meet technical requirements)

2 = Concern (only meets technical requirements not necessarily intent)

3 = Acceptable (meets intent as well as technical requirements)

4 = Exemplary (exceeds performance expectations)

B via 17

Rating

RSN/PHP REVIEW PROTOCOL

2000

	<p>6. What evidence or documentation can the Contractor provide to establish that complaints and grievances at all levels are tracked and integrated into the quality management process?</p> <ul style="list-style-type: none"> • Service provider level • RSN level • Ombuds level • (MHD level) 	<p>Exhibit I Page 1-13.(r)</p> <p>Federal Waiver Interest</p>
	<p>7. Since the last MHD review to what extent has the Ombuds been successful in providing outreach, case finding, and assisting individuals in resolving complaints related to contracted services? Note: Contracted services include all contracted and subcontracted services. These include, but not limited to:</p> <ul style="list-style-type: none"> • State Hospitals • Local hospitals • Jails • Shelters <p>What is your plan to address outreach for those areas where there is a demonstrated need but the Ombuds does not have access to provide advocacy/outreach?</p>	<p>Federal Waiver page 11</p> <p>Exhibit D (1)</p>
	<p>8. How does the Contractor and its subcontractors utilize Ombuds reports and their recommendations?</p> <p>Can the Contractor provide us with examples of how Ombuds reports and recommendations were analyzed?</p>	<p>Federal Waiver page 12</p> <p>Exhibit D (7)</p>

RATING KEY:

1 = Finding (does not meet technical requirements)

2 = Concern (only meets technical requirements not necessarily intent)

3 = Acceptable (meets intent as well as technical requirements)

4 = Exemplary (exceeds performance expectations)

B. VIA-18

Rating

RSN/PHP REVIEW PROTOCOL

2000

	How decisions were made? What follow up activities and interventions were made?	
	<p>9. As a result of the Ombuds accessing the Contractor and subcontractors what information and/or feedback has the Contractor received from the Ombuds regarding: The quality of care?</p> <p>The degree to which services are recipient focused/directed?</p> <p>The extent of development of alternatives to hospitalizations, cross-system coordination and range of treatment options?</p> <p>The degree that consumers are satisfied with services offered?</p>	<p>Federal Waiver page 11 Exhibit D (1) & (2)</p>
	<p>10. What controls are in place to assure that no retaliation is possible by the RSN/PHP Administrator or anyone else based upon how the Ombuds advocates for consumers?</p> <p>Is there is a RSN policy? Has retaliation occurred?</p> <p>What was done about it?</p>	<p>Exhibit D (10), Federal Waiver page 13, Criteria for Consultants' Review of RSN Applications for Integrated Contracts page 11.</p>

RATING KEY:

1 = Finding (does not meet technical requirements)
2 = Concern (only meets technical requirements not necessarily intent)

3 = Acceptable (meets intent as well as technical requirements)
4 = Exemplary (exceeds performance expectations)

B. VIa - 19

RSN/PHP REVIEW PROTOCOL

2000

QUALITY REVIEW TEAM (QRT)*Prior year Strengths:**Prior year Quality Improvements:*

	1. What does the Contractor perceive as the strengths of its quality review team?	Note: The QRT is not required to consist of 51% consumers Fed Waiver page 24. The teams shall include past or current services recipients and family members. MHD Contract H-1
	2. What does the Contractor perceive as the challenges of its quality review team?	
	3. To what extent has the QRT had access to systemic issues? <ul style="list-style-type: none"> Physical safety Emotional safety (honest respectful services, freedom from coercion, retaliation and intimidation) Service recipient satisfaction The system quality of care The degree to which services are consumer-focused/directed The extent of development of alternatives to hospitalization, cross-system coordination and range of treatment options 	Federal Waiver page 12, Exhibit E (1)

RATING KEY:

1 = Finding (does not meet technical requirements)

2 = Concern (only meets technical requirements not necessarily intent)

3 = Acceptable (meets intent as well as technical requirements)

4 = Exemplary (exceeds performance expectations)

B. Via - 20

Rating

RSN/PHP REVIEW PROTOCOL

2000

	Has there been any system improvements as a result of QRT identified issues in any of these areas?	
	<p>4. How has the RSN assured that the QRT has been afforded the opportunity to be part of the process for <u>contracting</u> activities?</p> <p>Note: This contract form is not specific and may include any level.</p>	Exhibit E #6
	<p>5. Has the QRT evaluated the RSN's relationships and cross system activities including, but not limited to:</p> <ul style="list-style-type: none"> • schools, • state hospitals, • local hospitals, • jails, • shellers? <p>What were the results of the QRT evaluation?</p>	Federal Waiver page 13 Exhibit E #3

RATING KEY:

1 - Finding (does not meet technical requirements)

2 - Concern (only meets technical requirements not necessarily intent)

3 - Acceptable (meets intent as well as technical requirements)

4 - Exemplary (exceeds performance expectations)

B. via -21

Rating

RSN/PHP REVIEW PROTOCOL

2000

<p>6. To what extent has the QRT conducted monitoring of the <u>RSN or subcontractors</u> quality management plan implementation?</p> <p>How did the QRT do this?</p> <p>What were the results?</p>	<p>Exhibit E #7</p>
<p>7. Have the QRT quarterly reports been distributed to at least the following stakeholders:</p> <p>Yes No</p> <p><input type="checkbox"/> <input type="checkbox"/> RSN Administration</p> <p><input type="checkbox"/> <input type="checkbox"/> Governing Board</p> <p><input type="checkbox"/> <input type="checkbox"/> Advisory Board</p> <p><input type="checkbox"/> <input type="checkbox"/> Ombuds</p> <p><input type="checkbox"/> <input type="checkbox"/> Local consumer/family advocate groups</p> <p><input type="checkbox"/> <input type="checkbox"/> Service area mental health advisory boards</p> <p><input type="checkbox"/> <input type="checkbox"/> Provider network</p> <p>Other _____</p>	<p>Exhibit E #8</p>
<p>8. How does the Contractor document that QRT reports, recommendations and finding are analyzed and how are decisions made regarding follow-up activities?</p> <p>How do QRT activities get incorporated into ongoing operations?</p> <p>Examples?</p>	<p>Exhibit E #9</p>

RATING KEY:

- 1 = Finding (does not meet technical requirements)
 2 = Concern (only meets technical requirements not necessarily intent)

- 3 = Acceptable (meets intent as well as technical requirements)
 4 = Exemplary (exceeds performance expectations)

B. VIa - 22

Rating

RSN/PHP REVIEW PROTOCOL

2000

<p>9. What mechanisms does the Contractor have in place to detect and deal with retaliation issues for the QRT should they arise?</p> <p>Has there been any retaliation issues since our last review?</p>	<p>Exhibit E #11</p> <p>Note: The RSN may want to establish a regional policy on retaliation and include a working definition.</p>
<p>10. How has the QRT progressed in meeting the Federal Waiver requirement of conducting focused interviews of at least 1% annually.</p> <p>Does the QRT have a work plan for attaining and maintaining this requirement?</p> <p>Monthly Average Clients Served _____</p> <p>Annual goal 1% equals _____</p> <p>Number of focused interviews conducted to date _____?</p> <p>11. Has the QRT made a visit to each service location once per biennium in the process of conducting the focused interviews?</p> <p>What barriers have they encountered, if any?</p>	<p>Attachment H of the Federal Waiver.</p> <p>Note the 2% requirement is based upon a <u>biennium</u> (attachment H of federal waiver formerly exhibit F of the federal waiver). Beginning July 1, 1999 ending June 30, 2001.</p> <p>Attachment H of the Federal Waiver.</p>
<p>12. Have the QRT Interview activities resulted in their ability to comment on:</p> <ul style="list-style-type: none"> • Access? 	<p>HCFA Interest -</p> <p>Note: This is the purpose of the integrated reviews.</p>

RATING KEY:

- 1 - Finding (does not meet technical requirements)
- 2 - Concern (only meets technical requirements not necessarily intent)

- 3 - Acceptable (meets intent as well as technical requirements)
- 4 - Exemplary (exceeds performance expectations)

B. VIa-23

Rating

RSN/PHP REVIEW PROTOCOL

2000

	<ul style="list-style-type: none"> • Quality of Care? • Acceptability? • Consumer satisfaction? 	
	<p>13. Does the QRT meet formally and informally on a regular basis?</p> <p>Has the Contractor ever been asked to facilitate these meetings by the QRT?</p> <p>How does this impact the functional independence of the QRT?</p>	Exhibit E #17
	<p>14. Have QRT teams met with individuals representing the interests of :</p> <ul style="list-style-type: none"> • Older persons? • Children? • Ethnic Minorities? <p>This may be somewhat redundant as this discussion may have already addressed earlier (QRT focused interviews/plans)</p>	Attachment H of federal waiver #4
	<p>15. Functional Independence</p> <p>How does the contractor assure functional independence of the QRT within the service area?</p> <p>Note: We may want to ask if the RSN has developed any regional policies and procedures to assure that the QRT will maintain functional independence, although they are not required to do so.</p>	<p>Federal Waiver page 12</p> <p>Exhibit E #10</p> <p>See application</p>

RATING KEY:

- 1 = Finding (does not meet technical requirements)
 2 = Concern (only meets technical requirements not necessarily intent)

- 3 = Acceptable (meets intent as well as technical requirements)
 4 = Exemplary (exceeds performance expectations)

B. VIA - 24

Rating

RSN/PHP REVIEW PROTOCOL

2000

--	--	--

RATING KEY:

- 1 = Finding (does not meet technical requirements)
- 2 = Concern (only meets technical requirements not necessarily intent)

- 3 = Acceptable (meets intent as well as technical requirements)
- 4 = Exemplary (exceeds performance expectations)

B.VIa - 25

RSN/PHP REVIEW PROTOCOL

2000

II. CROSS SYSTEM COLLABORATION

<p>Current Legislative Issues/Actions: (Laws of the 1999 Session)</p> <p>SHB 1620 Vulnerable Adults There has been a change and further specificity in definitions regarding abuse/neglect of adults over age 60. Requires DSHS employees, social workers, individual providers, facility employees, employees of MH centers, and others to report abuse, neglect, financial exploitation, or abandonment of vulnerable adults.</p> <p>1. <i>Does the RSN anticipate the need for training staff on this? Either at the RSN level or the providers level?</i></p> <p>SSB 5314a Youths in Possession of firearms at school. Requires CDMHP Evaluation of students who are arrested and charged with possession of a firearm on school facilities.</p> <p>2. <i>How is this being coordinated with schools within the catchment area?</i></p> <p>SSB 5312 Prevention of workplace violence in health care settings. Requires DSHS and others (Contractors / RSN) to develop and coordinate technical assistance and training seminars on plan development and implementation. The Mental health centers, community hospitals, and E & T facilities all must comply with this law.</p> <p>3. <i>What is the RSN/provider plan to address this?</i></p>	
---	--

RATING KEY:

- 1 = Finding (does not meet technical requirements)
2 = Concern (only meets technical requirements not necessarily intent)

- 3 = Acceptable (meets intent as well as technical requirements)
4 = Exemplary (exceeds performance expectations)

B. Via - 26

Rating

RSN/PHP REVIEW PROTOCOL

2000

PUBLIC SAFETY

	<p><i>Prior year strengths:</i></p> <p><i>Prior year quality improvements:</i></p>	
	<p>1. Is the Contractor adhering to their approved plan for serving persons of all ages with mental illness who are homeless?</p> <p>Is implementation occurring according to the approved plan?</p> <p>Are these services provided in all areas of the region?</p> <p>Have there been any barriers to implementation?</p>	Application item
	<p>2. Approximately how many homeless individuals have been identified within the region?</p> <p>Are there any patterns to homeless concentrations/penetrations within the region? Children? Seasonal variations?</p>	No Authority unless its in the Application -
	<p>3. How are the homeless populations and their needs being tracked?</p>	No Authority unless its in the Application -

RATING KEY:

- 1 = Finding (does not meet technical requirements)
 2 = Concern (only meets technical requirements not necessarily intent)

- 3 = Acceptable (meets intent as well as technical requirements)
 4 = Exemplary (exceeds performance expectations)

B.Vla - 27

Rating

RSN/PHP REVIEW PROTOCOL

2000

4. Is there an established Homeless mental health outreach person with specific skills and training for accessing and engaging homeless individuals?	No Authority unless its in the Application -
5. Is there a designated MHP qualified staff person to do face to face evaluations with homeless individuals?	No Authority unless its in the Application -
6. Have levels of care criteria for housing been implemented?	No Authority unless its in the Application -
7. Has the Contractor maintained (according to its approved plan) connections with local jails and regional prison administrators to improve strategies to ensure mentally ill persons are served appropriately? Is implementation occurring according to the approved plan? Are these services provided in all areas of the region? Have their been any barriers to implementation? How does the RSN monitor this?	Contract page 21 - 7.1.1. See application page
8. Have Jail diversion protocols been developed ?	No Authority unless its in the Application -

RATING KEY:

- 1 = Finding (does not meet technical requirements)
2 = Concern (only meets technical requirements not necessarily intent)

- 3 = Acceptable (meets intent as well as technical requirements)
4 = Exemplary (exceeds performance expectations)

BVIA-28

Rating

RSN/PHP REVIEW PROTOCOL

2000

	9. Are brochures that describe the jail diversion plans placed in Jails? Where else?	No Authority unless it is in the Application -	
--	---	--	--

RATING KEY:

1 = Finding (does not meet technical requirements)
2 = Concern (only meets technical requirements not necessarily intent)

3 = Acceptable (meets intent as well as technical requirements)
4 = Exemplary (exceeds performance expectations)

B. VIa-29

Rating

RSN/PHP REVIEW PROTOCOL

2000

CROSS SYSTEM COLLABORATION - GENERAL

	Prior year strengths:	
	Prior year quality improvements:	
	<p>The contractor shall work in active partnership with the following allied community providers to ensure that service recipients receive a balanced, coordinated and individualized array of quality supports and services;</p> <p>The following cross system entities were discussed on this review:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Tribal Authorities <input type="checkbox"/> Alcohol and Substance Abuse Programs <input type="checkbox"/> Regional Office of Developmental Disabilities <input type="checkbox"/> Regional Office of Aging and Adult Services <input type="checkbox"/> Regional Office of Children and Family Services <input type="checkbox"/> Free Standing evaluation and treatment Facilities <input type="checkbox"/> The Local AIDS Network <input type="checkbox"/> Local Schools <input type="checkbox"/> Local Medicaid managed care plans, Health Options and <input type="checkbox"/> Basic Health Plan Plus 	<p>Federal Waiver page 9</p>

RATING KEY:

- 1 = Finding (does not meet technical requirements)
 2 = Concern (only meets technical requirements not necessarily intent)

- 3 = Acceptable (meets intent as well as technical requirements)
 4 = Exemplary (exceeds performance expectations)

B. VIa - 30

Rating

RSN/PHP REVIEW PROTOCOL

2000

<input type="checkbox"/> Regional Office of Vocational Rehabilitation <input type="checkbox"/> Department of Corrections <input type="checkbox"/> DSHS Juvenile Rehabilitation Administration <input type="checkbox"/> County Juvenile Courts <input type="checkbox"/> County Jails (all) <input type="checkbox"/> Local Hospitals	
---	--

RATING KEY:

1 = Finding (does not meet technical requirements)

2 = Concern (only meets technical requirements not necessarily intent)

3 = Acceptable (meets intent as well as technical requirements)

4 = Exemplary (exceeds performance expectations)

B v1a - 31

Rating

RSN/PHP REVIEW PROTOCOL

2008

TRIBAL AUTHORITIES	
1. What evidence can the RSN show that would demonstrate that they have developed working partnerships with the local tribes?	Integrated services contract page 30 # 13
2. How does the RSN assess the status of these working partnerships? Strengths: Challenges:	Integrated services contract page 31
3. What evidence can the Contractor show that they have tracked and incorporated feedback from the cross-system providers (tribes) regarding the quality of care and the quality of system coordination?	Federal waiver page 16

RATING KEY:

- 1 = Finding (does not meet technical requirements)
- 2 = Concern (only meets technical requirements not necessarily intent)

- 3 = Acceptable (meets intent as well as technical requirements)
- 4 = Exemplary (exceeds performance expectations)

B. Via - 32

Rating

RSN/PHP REVIEW PROTOCOL

2000

	<p>4. Has the Contractor collected, analyzed and displayed sufficient information to assure and demonstrate the capacity to manage cross system resources?</p> <p>Coordination of case management functions?</p> <p>Mutually developed treatment plans?</p> <p>Ethnic care services?</p>	<p>Federal Waiver page 16</p>
	<p>5. What barriers to multi-system planning, treatment and coordination of care has the RSN identified?</p> <p>What efforts have been made to address these barriers?</p>	<p>Page 27, 28(c)</p>
	<p>6. How does the Contractor monitor and assure that the service providers solicit and utilize feedback from the informal and natural support systems within the tribal communities?</p>	<p>Federal waiver page 17</p>
	<p>7. What technical assistance or supports does the contractor provide or receive from the allied system partners/tribes?</p> <p>Cross system staff development?</p> <p>Coordination of resources?</p> <p>Mutually developed innovative programs?</p>	

RATING KEY:

- 1 - Finding (does not meet technical requirements)
- 2 - Concern (only meets technical requirements not necessarily intent)

- 3 - Acceptable (meets intent as well as technical requirements)
- 4 - Exemplary (exceeds performance expectations)

B. VIa-33

Rating

RSN/PHP REVIEW PROTOCOL

2000

	8. What local system performance indicators and outcome measures does the Contractor utilize, if any, for measuring its performance with the tribes?	RSN Leadership app. oval - System Improvement Group and Exhibit I page 1-2 1.(b)
--	--	--

RATING KEY:

- 1 = Finding (does not meet technical requirements)
- 2 = Concern (only meets technical requirements not necessarily intent)

- 3 = Acceptable (meets intent as well as technical requirements)
- 4 = Exemplary (exceeds performance expectations)

B. VIa - 34

RSN/PHP REVIEW PROTOCOL

2000

ALCOHOL AND SUBSTANCE ABUSE

	<p>1. What evidence can the RSN show that would demonstrate that they have developed working partnerships with the local Alcohol and Substance Abuse providers?</p> <p>What would an organization chart of the local Alcohol and Substance Abuse system look like?</p>	Federal Waiver page 9, 31
	<p>2. How does the RSN assess the status of these working partnerships?</p> <p>Strengths:</p> <p>Challenges:</p>	Federal Waiver page 31
	<p>3. What evidence can the Contractor show that they have tracked and incorporated feedback from the cross-system Alcohol and Substance Abuse providers regarding the quality of care and the quality of system coordination?</p>	Federal Waiver Questions page 29, and 1998-1999 Integrated Review finding

RATING KEY:

1 = Finding (does not meet technical requirements)
 2 = Concern (only meets technical requirements not necessarily intent)

3 = Acceptable (meets intent as well as technical requirements)
 4 = Exemplary (exceeds performance expectations)

B. VIa - 35

Rating

RSN/PHP REVIEW PROTOCOL

2000

	<p>4. Has the Contractor collected, analyzed and displayed sufficient information to assure and demonstrate the capacity to manage cross system resources?</p> <p>Coordination of case management functions?</p> <p>Mutually developed treatment plans?</p> <p>Ethnic care services?</p>	<p>Federal Waiver page 16</p>
	<p>5. What barriers to multi-system planning, treatment and coordination of care has the RSN identified?</p> <p>What efforts have been made to address these barriers?</p>	<p>Federal Waiver Questions page 27, 28(c)</p>
	<p>6. How does the Contractor monitor and assure that the service providers solicit and utilize feedback from the informal and natural support systems?</p>	<p>Federal Waiver page 27</p>

RATING KEY:

- 1 = Finding (does not meet technical requirements)
- 2 = Concern (only meets technical requirements not necessarily intent)

- 3 = Acceptable (meets intent as well as technical requirements)
- 4 = Exemplary (exceeds performance expectations)

B.VIA - 36

RSN/PHP REVIEW PROTOCOL

2000

<p>7. What technical assistance or supports does the contractor provide or receive from the allied system partners?</p> <p>Cross system staff development?</p> <p>Coordination of resources?</p> <p>Mutually developed innovative programs?</p>	(Best practices)
<p>8. What local system performance indicators and outcome measures does the Contractor utilize, if any, for measuring its performance with the alcohol and substance abuse system?</p>	RSN Leadership Group, System Improvement Group (SIG), exhibit I, pages 1-2 (b).

RATING KEY:

- 1 = Finding (does not meet technical requirements)
 2 = Concern (only meets technical requirements not necessarily intent)

- 3 = Acceptable (meets intent as well as technical requirements)
 4 = Exemplary (exceeds performance expectations)

B. Via - 37

Rating

RSN/PHP REVIEW PROTOCOL

2000

Area Office of Aging and Adult Services

	<p>1. What evidence can the RSN show that would demonstrate that they have developed working partnerships/ collaborative agreements with the local office (s) of Aging and Adult Services?</p> <p>What would an organization chart of the local Aging and Adult Services look like?</p>	<p>Federal Waiver page 9, 31, WAC 388-17 -- Senior Citizens Services Programs</p>
	<p>2. How does the RSN assess the status of these working partnerships?</p> <p>Strengths:</p> <p>Challenges:</p>	<p>Federal Waiver page 31</p>
	<p>3. What evidence can the Contractor show that they have tracked and incorporated feedback from the cross-system providers regarding the quality of care and the quality of system coordination?</p> <p>PASSAR?</p>	<p>Federal Waiver Questions page 29,</p>

RATING KEY:

1 = Finding (does not meet technical requirements)
 2 = Concern (only meets technical requirements not necessarily intent)

3 = Acceptable (meets intent as well as technical requirements)
 4 = Exemplary (exceeds performance expectations)

B. Via - 38

Rating

RSN/PHP REVIEW PROTOCOL

2000

	<p>4. Has the Contractor collected, analyzed and displayed sufficient information/data to assure and demonstrate the capacity to manage cross system resources?</p> <p>Coordination of case management functions?</p> <p>Mutually developed treatment plans?</p> <p>In home services?</p> <p>Residential services?</p> <p>Ethnic care services?</p>	<p>Federal Waiver page 16</p>
	<p>5. What barriers to multi-system planning, treatment and coordination of care has the RSN identified?</p> <p>What efforts have been made to address these barriers?</p>	<p>Federal Waiver Questions page 27, 28(c)</p>
	<p>6. How does the Contractor monitor and assure that the service providers solicit and utilize feedback from the informal and natural support systems?</p>	<p>Federal Waiver page 27</p>

RATING KEY:

- 1 = Finding (does not meet technical requirements)
- 2 = Concern (only meets technical requirements not necessarily intent)

- 3 = Acceptable (meets intent as well as technical requirements)
- 4 = Exemplary (exceeds performance expectations)

B. Via - 39

RSN/PHP REVIEW PROTOCOL

2000

	<p>7. What technical assistance or supports does the contractor provide or receive from the allied system partners?</p> <p>Cross system staff development?</p> <p>Coordination of resources?</p> <p>Mutually developed innovative programs?</p>	
	<p>8. What local system performance indicators and outcomes measures does the Contractor utilize for measuring its performance in coordinating Aging and Adult Services?</p> <p>Have these performance indicators been mutually developed with Aging and Adult Services?</p>	RSN Leadership Group, System Improvement Group (SIG), exhibit I, pages 1-2 (b).

RATING KEY:

1 = Finding (does not meet technical requirements)

2 = Concern (only meets technical requirements not necessarily intent)

3 = Acceptable (meets intent as well as technical requirements)

4 = Exemplary (exceeds performance expectations)

B Via - 40

Rating

RSN/PHP REVIEW PROTOCOL

2000

Regional Office of Vocational Rehabilitation Services

	1. What evidence can the RSN show that would demonstrate that they have developed working partnerships with the local office (s) of Vocational Rehabilitation Services.	Federal Waiver page 9, 31
	2. How does the RSN assess the status of these working partnerships? Strengths: Challenges:	
	3. What evidence can the Contractor show that they have tracked and incorporated feedback from the cross-system providers regarding the quality of care and the quality of system coordination?	Federal Waiver Questions page 29

RATING KEY:

- 1 = Finding (does not meet technical requirements)
- 2 = Concern (only meets technical requirements not necessarily intent)

- 3 = Acceptable (meets intent as well as technical requirements)
- 4 = Exemplary (exceeds performance expectations)

B.VIA- 41

Rating

RSN/PHP REVIEW PROTOCOL

2000

	<p>4. Has the Contractor collected, analyzed and displayed sufficient information to assure and demonstrate the capacity to manage cross system resources?</p> <p>Coordination of case management functions?</p> <p>Mutually developed treatment plans?</p> <p>Ethnic care services?</p>	<p>Federal Waiver page 16</p>
	<p>5. What barriers to multi-system planning, treatment and coordination of care has the RSN identified?</p> <p>What efforts have been made to address these barriers?</p>	<p>Federal Waiver Questions page 27, 28(c)</p>
	<p>6. How does the Contractor monitor and assure that the service providers solicit and utilize feedback from the informal and natural support systems?</p>	<p>Federal Waiver page 27</p>
	<p>7. What technical assistance or supports does the contractor provide or receive from the allied system partners?</p> <p>Cross system staff development?</p> <p>Coordination of resources?</p>	

RATING KEY:

1 = Finding (does not meet technical requirements)

2 = Concern (only meets technical requirements not necessarily intent)

3 = Acceptable (meets intent as well as technical requirements)

4 = Exemplary (exceeds performance expectations)

B. VIA - 42

Rating

RSN/PHP REVIEW PROTOCOL

2000

	Mutually developed innovative programs?	
8.	What local system performance indicators and outcome measures does the Contractor utilize for measuring its performance in coordinating services with Vocational Rehabilitation Services? Have these system performance indicators been mutually developed with Vocational Rehabilitation Services?	RSN Leadership Group, System Improvement Group (SIG), exhibit I, pages 1-2 (b)

RATING KEY:

1 = Finding (does not meet technical requirements)
2 = Concern (only meets technical requirements not necessarily intent)

3 = Acceptable (meets intent as well as technical requirements)
4 = Exemplary (exceeds performance expectations)

B.VIa - 43

Rating

RSN/PHP REVIEW PROTOCOL

2000

Regional Office of Children and Family Services

	1. What evidence can the RSN show that would demonstrate that they have developed working partnerships with the local office(s) of Children and Family Services?	Federal Waiver page 9, 31
	2. How does the RSN assess the status of these working partnerships? Strengths: Challenges:	Federal Waiver page 31
	3. What evidence can the Contractor show that they have tracked and incorporated feedback from the cross-system providers regarding the quality of care and the quality of system coordination?	

RATING KEY:

1 = Finding (does not meet technical requirements)

2 = Concern (only meets technical requirements not necessarily intent)

3 = Acceptable (meets intent as well as technical requirements)

4 = Exemplary (exceeds performance expectations)

B. via- 41

Rating

RSN/PHP REVIEW PROTOCOL

2000

	<p>4. Has the Contractor collected, analyzed and displayed sufficient information to assure and demonstrate the capacity to manage cross system resources?</p> <p>Coordination of case management functions?</p> <p>Mutually developed treatment plans?</p> <p>Ethnic care services?</p>	<p>Federal Waiver page 16</p>
	<p>5. What barriers to multi-system planning, treatment and coordination of care has the RSN identified?</p> <p>What efforts have been made to address these barriers?</p>	<p>Federal Waiver Questions page 27, 28(c)</p>
	<p>6. How does the Contractor monitor and assure that the service providers solicit and utilize feedback from the informal and natural support systems?</p>	<p>Federal Waiver page 27</p>
	<p>7. What technical assistance or supports does the contractor provide or receive from the allied system partners?</p>	<p>(Best practices)</p>

RATING KEY:

1 = Finding (does not meet technical requirements)

2 = Concern (only meets technical requirements not necessarily intent)

3 = Acceptable (meets intent as well as technical requirements)

4 = Exemplary (exceeds performance expectations)

B.VIA-45

Rating

RSN/PHP REVIEW PROTOCOL

2000

	<p>Cross system staff development?</p> <p>Coordination of resources?</p> <p>Mutually developed innovative programs?</p>	
8	<p>What local system performance indicators and outcome measures does the Contractor utilize for measuring its performance in coordinating services with Children and Family Services?</p> <p>Have these system performance indicators been mutually developed with Children and Family Services?</p>	RSN Leadership Group, System Improvement Group (SIG), exhibit I, pages 1-2 (b).

RATING KEY:

- 1 = Finding (does not meet technical requirements)
- 2 = Concern (only meets technical requirements not necessarily intent)

- 3 = Acceptable (meets intent as well as technical requirements)
- 4 = Exemplary (exceeds performance expectations)

B.VI9 - 46

Rating

RSN/PHP REVIEW PROTOCOL

2000

Regional Office of Developmental Disabilities

	1. What evidence can the RSN show that would demonstrate that they have developed working partnerships with the local office(s) of Developmental Disabilities?	Federal Waiver page 9, 31
	2. How does the RSN assess the status of these working partnerships? Strengths: Challenges:	Federal Waiver page 31
	3. What evidence can the Contractor show that they have tracked and incorporated feedback from the cross-system providers regarding the quality of care and the quality of system coordination?	Federal Waiver Questions page 29

RATING KEY:

- 1 = Finding (does not meet technical requirements)
- 2 = Concern (only meets technical requirements not necessarily intent)

- 3 = Acceptable (meets intent as well as technical requirements)
- 4 = Exemplary (exceeds performance expectations)

B.Via - 47

RSN/PHP REVIEW PROTOCOL

2000

	<p>4. Has the Contractor collected, analyzed and displayed sufficient information to assure and demonstrate the capacity to manage cross system resources?</p> <p>Coordination of case management functions?</p> <p>Mutually developed treatment plans?</p> <p>Ethnic care services?</p>	Federal Waiver page 16
	<p>5. What barriers to multi-system planning, treatment and coordination of care has the RSN identified?</p> <p>What efforts have been made to address these barriers?</p>	Federal Waiver Question: page 27, 28(c)
	<p>6. How does the Contractor monitor and assure that the service providers solicit and utilize feedback from the informal and natural support systems?</p>	Federal Waiver page 27
	<p>7. What technical assistance or supports does the contractor provide or receive from the allied system partners?</p> <p>Cross system staff development?</p> <p>Coordination of resources?</p>	(Best practices)

RATING KEY:

1 = Finding (does not meet technical requirements)

2 = Concern (only meets technical requirements not necessarily intent)

3 = Acceptable (meets intent as well as technical requirements)

4 = Exemplary (exceeds performance expectations)

B. Via - 48

Rating

RSN/PHP REVIEW PROTOCOL

2000

	Mutually developed innovative programs?	
	8. What local system performance indicators and outcome measures does the Contractor utilize, if any, for measuring its performance in coordinating services for individuals with Developmental Disabilities?	RSN Leadership Group, System Improvement Group (SIG), exhibit I, pages 1-2 (b).

RATING KEY:

1 = Finding (does not meet technical requirements)

2 = Concern (only meets technical requirements not necessarily intent)

3 = Acceptable (meets intent as well as technical requirements)

4 = Exemplary (exceeds performance expectations)

B. VIa - 49

Rating

RSN/PHP REVIEW PROTOCOL

2000

III. QUALITY MANAGEMENT – CLINICAL COMPETENCY

RATING KEY:

1 = Finding (does not meet technical requirements)

2 = Concern (only meets technical requirements not necessarily intent)

3 = Acceptable (meets intent as well as technical requirements)

4 = Exemplary (exceeds performance expectations)

B Via - 50

Rating

RSN/PHP REVIEW PROTOCOL

2000

RATING KEY:

- 1 = Finding (does not meet technical requirements)
- 2 = Concern (only meets technical requirements not necessarily intent)

- 3 = Acceptable (meets intent as well as technical requirements)
- 4 = Exemplary (exceeds performance expectations)

B. VIa - 51

Rating

RSN/PHP REVIEW PROTOCOL

2000

QUALITY MANAGEMENT – CLINICAL COMPETENCY <i>Prior year strengths:</i>	
<i>Prior year quality improvements:</i>	
Quality Management- Staff Development	
1. What are the quality management processes that the RSN uses to evaluate staff who provide clinical services in order to assure (competency) that the RSN is prepared to meet the needs of the entire population needing services, not just those currently enrolled? If the contractor is subcontracting for these services, how are they (RSN) monitoring this? What are the results of their monitoring? Does the RSN have policies and procedures to address these issues (outcomes, clinical guidelines, quality indicators)?	MHD response to HCFA questions, section 1 page 15

RATING KEY:

- 1 = Finding (does not meet technical requirements)
- 2 = Concern (only meets technical requirements not necessarily intent)

- 3 = Acceptable (meets intent as well as technical requirements)
- 4 = Exemplary (exceeds performance expectations)

B. Via -52

Rating

RSN/PHP REVIEW PROTOCOL

2000

	<p>2. Are there special populations unique to this particular RSN?</p> <p>Does staff development and training activities include serving clients of diverse cultures?</p>	(Best practices)
	<p>3. Does clinical supervision include specific involvement of cultural and age specific specialists</p>	(Best practices)

RATING KEY:

1 - Finding (does not meet technical requirements)

2 - Concern (only meets technical requirements not necessarily intent)

3 - Acceptable (meets intent as well as technical requirements)

4 - Exemplary (exceeds performance expectations)

B. VIa- 53

Rating

RSN/PHP REVIEW PROTOCOL 2000

QUALITY MANAGEMENT INPATIENT MANAGEMENT/UTILIZATION

Prior year strengths:

•

Prior year quality improvements:

Prior Year Findings:

	<p>QUALITY MANAGEMENT</p> <p>CRISIS SERVICES</p> <p><i>Prior year strengths:</i></p> <p><i>Prior year quality improvements:</i></p> <p><i>Prior Findings:</i></p>
	<p><i>To what extent has the contractor complied with, respected and utilized Advanced Directives and / or crisis plans for the psychiatric care for service recipients who are experiencing situations for which they have planned in advance and created this directive so long as they are clinically appropriate?</i></p> <p>Contract 2.2.4, Federal Waiver page17</p>

RATING KEY:

- 1 = Finding (does not meet technical requirements)
- 2 = Concern (only meets technical requirements not necessarily intent)

- 3 = Acceptable (meets intent as well as technical requirements)
- 4 = Exemplary (exceeds performance expectations)

B. VIA - 54

Rating

RSN/PHP REVIEW PROTOCOL

2000

	<i>Results of MHD crisis line testing (2000):</i>	

RATING KEY:

- 1 = Finding (does not meet technical requirements)
2 = Concern (only meets technical requirements not necessarily intent)

- 3 = Acceptable (meets intent as well as technical requirements)
4 = Exemplary (exceeds performance expectations)

B. v1a - 55



RSN/PHP REVIEW PROTOCOL

2000

QUALITY MANAGEMENT GENERAL PROTOCOL

Prior year Strengths:

Prior year Quality Improvements:

<p>Quality Management – HCFA Summary of compliance</p> <p>Intent and purpose of PHP QM:</p> <p>The PHP level Quality Management (QM) processes shall monitor system capacity, the intensity of services and supports being provided, and the outcomes being achieved through those services. This process must track system capacity, quality of clinical care, as well as the intensity and appropriateness of care.</p> <p>Note: Significant changes to the QM plan must be submitted to the MHD for approval.</p>	<p>Federal waiver page 15, Contract 1.1 and 4.4</p>
<p>What are the components of this RSN Quality Management system and how do these components interact with each other to form the QM system?</p> <p>Is there a schematic diagram that would help explain this system and how it interacts?</p>	

RATING KEY:

- 1 – Finding (does not meet technical requirements)
- 2 – Concern (only meets technical requirements not necessarily intent)

- 3 – Acceptable (meets intent as well as technical requirements)
- 4 – Exemplary (exceeds performance expectations)

B. VIa-56

Rating

RSN/PHP REVIEW PROTOCOL

2000

	<p>1. Are the contractors quality management plan specific time frames for implementation being adhered to?</p> <p>What if any barriers have been encountered?</p>	<p>Federal Waiver page 15 Contract 4.1.1, and Exhibit f, page 1-1</p>
	<p>2. Does the RSN regularly manage utilization through a process independent of direct service providers?</p>	<p>WAC 275-57-110 (2)</p>
	<p>3. What evidence or documentation can the Contractor provide to establish that it has implemented an analysis of care provided to at least ten (10) percent or 500 total (if smaller) representative sampling of service recipients on an annual basis. <i>(The following qualify for the 10 % sampling: Chart Reviews, Concurrent reviews, Surveys, Focus Groups, Individual Interviews, Ombuds reviews of complaints or grievances)</i></p> <p>Estimated number of clients served annually _____ Documented number of analysis of care conducted _____ Percentage _____</p>	<p>Federal Waiver page 16, and Contract Exhibit I</p>

RATING KEY:

- 1 = Finding (does not meet technical requirements)
2 = Concern (only meets technical requirements not necessarily intent)

- 3 = Acceptable (meets intent as well as technical requirements)
4 = Exemplary (exceeds performance expectations)

B.VIa-57

Rating

RSN/PHP REVIEW PROTOCOL

2000

	<p>4. Has the Contractor collected, analyzed and displayed sufficient information to assure and demonstrate the capacity to manage resources and deliver appropriate quality and intensity of services including, but not limited to, access to services, resource management, crisis system and (other) services?</p> <p>Aspect of care, service system operations, and management capability to be analyzed include:</p> <ul style="list-style-type: none"> Clinical Care (see question # 5) Service System (see question # 6) Administrative, (performance and efficiency of service provider network). 	<p>Federal Waiver page 16 and Exhibit I of Contract</p>
	<p>5. Has the Contractor demonstrated <u>implementation</u> of its analysis of Clinical Care through the following:</p> <p>Note: This item must be coordinated with the clinical team.</p> <ul style="list-style-type: none"> The clinical appropriateness or fit between what was needed and what was received The degree to which services provided are driven by recipient needs The degree to which services and planning incorporate the service recipients voice The degree to which services and planning are age, culturally and linguistically competent The degree to which services are provided in the least restrictive environment The degree to which needs for housing, employment and education options were assessed and support and services provided 	<p>Federal Waiver page 17 and Exhibit I of Contract</p>

RATING KEY:

- 1 = Finding (does not meet technical requirements)
- 2 = Concern (only meets technical requirements not necessarily intent)

- 3 = Acceptable (meets intent as well as technical requirements)
- 4 = Exemplary (exceeds performance expectations)

B. VIa - 58

Rating

RSN/PHP REVIEW PROTOCOL

2000

	<ul style="list-style-type: none"> • The degree to which there was inclusion, recruitment and use of natural supports and other community resources • The degree to which there are appropriate linkages and integration with other systems and settings • The degree to which there was congruency between the chart including assessment, treatment plan, and progress notes and the actual services and supports provided • Performance regarding clinical care are within acceptable ranges 	
	<p>6. Has the Contractor demonstrated <u>implementation</u> of its analysis of the Service System for:</p> <p>Services for underserved populations are accessible,</p> <p>Services are accessed promptly, geographically accessible, convenient and timely,</p> <p>Without waiting lists for Medicaid recipients,</p> <p>Adequate triage for all settings of care (inpatient, urgent care, and outpatient services and supports)</p>	<p>Federal Waiver page 17 and Exhibit I of Contract</p>

RATING KEY:

- 1 = Finding (does not meet technical requirements)
 2 = Concern (only meets technical requirements not necessarily intent)

- 3 = Acceptable (meets intent as well as technical requirements)
 4 = Exemplary (exceeds performance expectations)

BV1a- 59

Rating

RSN/PHP REVIEW PROTOCOL

2000

	7. What examples can the Contractor provide that demonstrates that it has an effective process for analyzing and interpreting information, making recommendations and developing strategies for action?	Federal waiver page 16, Exhibit I page 1-2 (2).
	8. Is the PHP's interpretation of the data that is being collected shared with practitioners on a regular basis? What feedback have you received?	Federal Waiver page 24, #4 Contract Exhibit I

RATING KEY:

1 = Finding (does not meet technical requirements)

2 = Concern (only meets technical requirements not necessarily intent)

3 = Acceptable (meets intent as well as technical requirements)

4 = Exemplary (exceeds performance expectations)

B VIa - 60

Rating

RSN/PHP REVIEW PROTOCOL

2000

	<p>9. Has the Contractor performed periodic evaluation(s) of its overall quality management System?</p> <p>What is the results of the last evaluation performed ?</p> <p>What system improvements have occurred as a result of this evaluation?</p> <p>What involvement have all of the above had in this process?</p>	<p>Contract Exhibit I page 1-1 Federal waiver page 16, (h).</p>
	<p>10. Has the contractor provided an independent review of the quality of care through a process operated by a majority of current or past recipients and their family members?</p> <p>Note: This independent review may be conducted by the QRT</p>	<p>Federal waiver page 24, (#3) Contract Exhibit I, page 1-1</p>
	<p>11. Has the Contractor undertaken any focused studies since the last on-site review to improve/understanding the system of care?</p>	<p>Exhibit I page 1-1</p>
	<p>12. What examples can the Contractor provide that demonstrates it has identified deficiencies and has take action to correct them?</p> <ul style="list-style-type: none"> • Analysis of Care • On-site RSN audits 	<p>Federal waiver page 24, Contract exhibit I, page 1-1</p>

RATING KEY:

- 1 = Finding (does not meet technical requirements)
2 = Concern (only meets technical requirements not necessarily intent)

- 3 = Acceptable (meets intent as well as technical requirements)
4 = Exemplary (exceeds performance expectations)

B.Via - 61

Rating

RSN/PHP REVIEW PROTOCOL

2000

	<p>13. How does the RSN utilize the critical incident reports (trends) for system improvements?</p> <p>Give some examples.</p>	
	<p>14. What local system performance indicators and outcomes does the Contractor utilize, if any, for measuring quality management?</p> <p>How does your focus on system performance indicators compare to the Santiago model, Structure, Process, Outcomes?</p>	<p>RSN Leadership approval - System Improvement Group and Exhibit I page 1-2 1(b) Federal Waiver page 24</p>
	<p>15. What is the results of the Contractor tracking Complaints and Grievances processes?</p> <p>Note: We are trying to substantiate this HCFA finding.</p> <p>At what levels are these being tracked?</p> <p>Is there any RSN data which would indicate that the vast majority of complaints/grievances have been made regarding:</p> <ul style="list-style-type: none"> • Consumer Rights, • Access, • Quality of Services, • Service intensity, 	<p>Federal waiver page 16 MHD response to HCFA questions page 36 Q5</p>

RATING KEY:

- 1 = Finding (does not meet technical requirements)
2 = Concern (only meets technical requirements not necessarily intent)

- 3 = Acceptable (meets intent as well as technical requirements)
4 = Exemplary (exceeds performance expectations)

B. VIA - 62

Rating

RSN/PHP REVIEW PROTOCOL

2000

	<ul style="list-style-type: none"> •Service not available, or •Coordination of services 	
	<p>16. Please describe any action the RSNs have taken or plan to take to reduce the number of complaints and grievances received.</p> <p>Note: This is a HCFA question (verbatim). We may not want to reduce the number of complaints per se, but rather improve the system and improve the consumer satisfaction through a process that addresses the reason for the complaints.</p>	MHD response to HCFA questions.
	<p>17. At which point and through what means are consumers notified about:</p> <ul style="list-style-type: none"> • changes, • denials, • terminations from service, • or reductions in services available to them, both individually and as a group? <p>What are the RSN's system wide policy and oversight relating to this requirement?</p>	MHD response to HCFA questions (access to services) page: 11 (a)
	<p>18. Clarify the process through which consumers are provided information about and access to their rights and responsibilities, their right to disenroll.</p> <p>What is known about dis-enrollments within the RSN?</p>	<p>Federal Waiver page 19.</p> <p>MHD response to HCFA questions (access to services) page 18 (c)</p> <p>The federal waiver (section N, Client Disenrollment), states: As part of the informal and formal PHP grievance procedures, and through the DSHS Fair</p>

RATING KEY:

- 1 = Failing (does not meet technical requirements)
2 = Concern (only meets technical requirements not necessarily intent)

- 3 = Acceptable (meets intent as well as technical requirements)
4 = Exemplary (exceeds performance expectations)

B. V19- 63

RSN/PHP REVIEW PROTOCOL

2000

Number of requests?
 Number of occurrences?
 Reasons for requests?

Hearing process, if necessary, a recipient may seek disenrollment from a PHP for good cause. Good cause is defined as an inability of the PHP to provide appropriate access or care within the scope of the waiver defined services.

It further states, "A recipient may use the grievance process and ombudsperson to seek disenrollment from his/her assigned PHP and enrollment in the neighboring PHP". If a Medicaid service is needed by a recipient and is not provided by the PHP, the recipient may obtain that service with a medical ID card through the usual fee-for-service program.

In the Washington State HCFA Waiver, Question Responses 1. Access to Services, it states:

"It appears to HCFA, from review of these materials that, at a functional level, the waiver and RSN structure as it is currently implemented, precludes the right of a recipient to disenroll." "It is conceivable, therefore, that instances would occur in which a particular individual's needs could not be met with the services available through the RSN to which they are assigned. In those instances, for those individuals, the disenrollment process must be accessible and functional: they must have an alternative option for receiving the treatment they need."

"HCFA needs to be assured that individuals have option of adequate access to a functional disenrollment process in all RSNs and at the State level." (page 14)

see Spokane RSN P/P page 3/4 (Care termination)

Note: Add additional items that are specific to each RSN Application

RATING KEY:

- 1 = Finding (does not meet technical requirements)
 2 = Concern (only meets technical requirements not necessarily intent)

- 3 = Acceptable (meets intent as well as technical requirements)
 4 = Exemplary (exceeds performance expectations)

B VIA - 64

Rating

RSN/PHP REVIEW PROTOCOL

2000

Quality Management ~ MIS

Prior Year Strengths:

Prior Year Quality Improvements:

The Contractor will attest to the integrity of the management information system data being reported.

Does the RSN perform validation checks of reported information to the source record? (not specifically required but standard practice)

Federal waiver page 16,
Exhibit I page 1-1 3.(k)

RATING KEY:

- 1 = Finding (does not meet technical requirements)
- 2 = Concern (only meets technical requirements not necessarily intent)

- 3 = Acceptable (meets intent as well as technical requirements)
- 4 = Exemplary (exceeds performance expectations)

BVIa - 65

Rating

RSN/PHP REVIEW PROTOCOL

2000

QUALITY MANAGEMENT FISCAL

	<p>1. Maintain the capacity to reimburse the subcontracted provider network and any emergency service providers accessed by service recipients or potential service recipients while out of the service area within 60 days using the methods consistent with generally accepted accounting principles. Has the RSN had to reimburse service providers outside the service area for emergency services (RSN level, service provider level)?</p>	<p>MHD/RSN Contract (6.1.2; 6.1.10;</p>
	<p>2. Ensure that each provider in the RSN has a sliding fee scale. The sliding fee scale schedule shall be posted and accessible to staff and service recipients and may not require payment from service recipients with income levels equal to or below the grant standards for the general assistance program. How is this being monitored by the RSN?</p>	<p>MHD/RSN Contract (6.1.2; 6.1.10; Note, this is a licensing functioning. There is a sliding fee scale in the application but don't know if each provider uses it.</p>
	<p>3. Are there subcontractors in the RSN that receive more than \$300,000 each? How many have had the required biennial audit How is this being monitored by the RSN?</p>	<p>MHD/RSN Contract (6.1.2; 6.1.10;</p>

RATING KEY:

- 1 = Finding (does not meet technical requirements)
2 = Concern (only meets technical requirements not necessarily intent)

- 3 = Acceptable (meets intent as well as technical requirements)
4 = Exemplary (exceeds performance expectations)

B. Via - 66

RSN/PHP REVIEW PROTOCOL

2000-2001

ADVISORY BOARD and RSN/PHP INTERVIEW QUESTIONS	RESPONSE
<p>1. Does the Advisory Board membership consist of at least 51% members who are consumers, past consumers, family or foster family members of consumers including parents of emotionally disturbed children, of the public mental health system.</p> <p>Total Membership _____</p> <p>Percentage of consumers/family _____</p> <p>Number of active members _____</p>	<p>WAC 275-57-080 (2)(a)</p> <p>The intent and purpose here is to assure that the consumers have a significant voice in the planning, implementation and assessment of mental health services. There should be active involvement of all consumers who are on this Advisory Board</p>
<p>2. What, if any, changes have occurred in the Advisory Board composition since the last review?</p>	<p>WAC 275-57-080 (2) (a)</p>
<p>3. Has the RSN maintained an Advisory Board that is broadly representative of the demographic character of the region?</p>	<p>WAC 275-57-080 (2) (a)</p>
<p>4. Has the advisory board provided comments and or recommendation to the RSN/PHP regarding:</p> <ul style="list-style-type: none"> • <u>Plans?</u> • <u>Budgets?</u> • <u>Policies</u> 	<p>WAC 275-57-080(2)(b)</p>

B. via

RSN/PHP REVIEW PROTOCOL

2000-2001

<p>5. Have the Advisory Board's comments on plans, budgets, and policies been forwarded to the RSN Governance body and elected officials who are responsible for the mental health programs?</p> <p>What feed back have you received?</p>	<p>WAC 275-57-080 (2)(b)</p>
<p>6. What is your perspective regarding the current level of:</p> <p>consumer voice in this RSN/PHP?</p> <p>consumer satisfaction with services received?</p> <p>and quality of care in this RSN/PHP?</p>	<p>Federal Waiver Interest</p>

RSN/PHP REVIEW PROTOCOL

FORM 2001

OMBUDS, RSN/PHP and Subcontractors (*) INTERVIEW QUESTIONS	RESPONSE
1. Has there been any structural changes with regards to the Ombuds services since our last on-site review?	Federal Waiver page 11, The PHP shall assure and support full contract compliance for functionally independent Ombuds. Exhibit D (8) Note: What are turnover and gaps in the Ombuds services? This has significant impact on the consumers and their access to Ombuds services
2. (*) Has the contractor/PHP assured recipients and potential service recipients access to Ombuds services to assist/represent/advocate for them if requested regarding complaints, grievance, fair hearing and ITA process?	Exhibit D, (13)
3. (*) Is there adequate Ombuds to meet workload needs?	Exhibit D, (13)
4. (*) Has the Contractor/PHP assured that the Ombuds has access to the contractor and all subcontractors regarding: ♦ Consumer Voice? ♦ The quality of care? ♦ The degree to which services are recipient focused/directed? ♦ The extent of development of alternatives to hospitalizations, cross-system coordination and range of treatment options?	Federal Waiver page 11 Exhibit D (1)

B. Via ³

RSN/PHP REVIEW PROTOCOL

2000-2001

<p>5. (*) Has the contractor/PHP assured that the Ombuds has the authority to enter into a service area contracting with the contractor or Mental Health Division for the purpose of outreach, case finding and to resolve individual complaints related to the contracted services?</p> <p>Note: Contracted services include all contracted and subcontracted services. These include, but not limited to:</p> <ul style="list-style-type: none"> • State Hospitals • Local hospitals • Jails • Shelters <p>Has the contractor/PHP facilitated access for this to occur (if necessary)?</p> <p>To what extent has the Ombuds been successful in providing outreach, case finding, and assisting individuals in resolving complaints related to these contracted services?</p>	<p>Federal Waiver page 11 Exhibit D (1)</p>
<p>6. As a result of the Ombuds information gathering activities and reports, what did the Contractor/PHP learn about:</p> <ul style="list-style-type: none"> • Physical safety (food, health, housing) • Emotional safety (honest/respectful services, freedom from coercion, intimidation) • Service recipient satisfaction? 	<p>Federal Waiver page 11 Exhibit D (2)</p>

RSN/PHP REVIEW PROTOCOL

2000-2003

<p>7. (*) Has the contractor and all subcontractors considered the Ombuds findings and reports in good faith?</p> <p>Can you provide us with examples of how Ombuds reports and recommendations were analyzed?</p> <p>How decisions were made regarding follow up activities and interventions?</p> <p>How are Ombuds reports utilized by Service providers? Give examples.</p>	<p>Federal Waiver Requirement page 12 Exhibit D (7) Note: The contractor and subcontractors shall demonstrate how the Ombuds reports, recommendations and findings are analyzed and how decisions are made regarding follow up activities and interventions as well as demonstrate how issues are addressed and incorporated into ongoing operations including but not limited to contracting activities and management decisions.</p>
<p>8. How effective have the controls been that assure that no retaliation is possible by the RSN/PHP Administrator or anyone else based upon how the Ombuds advocates for consumers?</p>	<p>Exhibit D (10), Federal Waiver page 13.</p>

B. Via ⁵

RSN/PHP REVIEW PROTOCOL

2000- 2001

QRT, RSN/PHP, Subcontractors (*), INTERVIEW QUESTIONS	RESPONSE
<p>1. How has the QRT progressed in meeting the Federal Waiver requirement of conducting "focus interviews" with recipients and family members, allied services and Members of the community to determine whether services are readily accessible and acceptable to recipients and address recipients needs. At least 2% of all service recipients shall be surveyed in this fashion each biennium.</p> <p>Monthly Average Clients Served _____</p> <p>Biennial goal _____</p> <p>Number of focused interviews conducted to date _____</p> <p>If not met, target completion date _____</p> <p>What are the results of these interviews?</p>	<p>Federal Waiver Attachment H (2)</p> <p>Note: The 2% requirement is based upon a <u>biennium</u> (attachment H of federal waiver formerly exhibit F of the federal waiver) Beginning July 1, 1999 ending June 30, 2001.</p>

RSN/PHP REVIEW PROTOCOL

2000-2001

<p>2. (*) Has the QRT made a visit to each service location at least once per biennium in the process of conducting the focused interviews?</p> <p>Number of service locations in the RSN/PHP _____</p> <p>Number of service locations visited to date _____</p> <p>If not met, target completion date _____</p> <p>What barriers have they encountered, if any?</p>	<p>Federal Waiver Attachment H, (2)</p>
<p>3. Have QRT teams met with individuals representing the interests of:</p> <ul style="list-style-type: none"> • Older persons, • Children, • Ethnic Minorities, <p>Do these populations know what services are provided within</p> <p>Do these services meet their needs?</p>	<p>Attachment H, federal Waiver (4)</p>
<p>4. (*) To what extent has the QRT had access to systemic issues of consumer welfare and have included family advocates in the assessment of systemic issues regarding?</p>	<p>Federal Waiver page 12, Exhibit E (1)</p>

B via ⁷

RSN/PHP REVIEW PROTOCOL

(000 000)

<ul style="list-style-type: none"> • Physical safety (food, health, housing), • Emotional safety (honest respectful services, freedom from coercion, retaliation and intimidation) • Service recipient satisfaction <p>What were the results?</p>	
<p>5. (*) Has the QRT, in the process of assessing systemic customer services, visited, assessed and evaluated the contractors services and services of subcontractors regarding:</p> <ul style="list-style-type: none"> • quality of care • The degree to which services are consumer-focused/directed and • The extent of development of alternatives to hospitalization, cross-system coordination and range of treatment options? <p>What are the results of this assessment?</p> <p>What system changes/improvements have been made as a results of the QRT assessment/evaluation (recommendations</p>	<p>Federal Waiver page 12. Contract Exhibit E. (2)</p>
<p>6. (*) What feedback have you received as a result of distributing the QRT quarterly reports to the following stakeholders:</p> <ul style="list-style-type: none"> • RSN Administrator, • Governing Board, • Advisory Board, 	<p>Exhibit E, (8)</p>

2000-2001

B. Via

RSN/PHP REVIEW PROTOCOL

0601 2001

<p>activities and other management decisions?</p> <p>Examples?</p> <p>What barriers have been encountered or identified?</p>	
<p>10. (*) What is the extent of the QRT evaluation of the RSN's relationships and cross system activities including, but not limited to:</p> <ul style="list-style-type: none"> • schools, • state hospitals, • local hospitals, • jails, • shelters <p>What are the results?</p> <p>What barriers have been identified?</p>	<p>Federal Waiver Page 13, Exhibit E (3)</p>
<p>12. What are the Quality Review Team plans for the next biennium?</p> <p>Please describe the major features of this plan.</p> <p>Note: This plan should include ways to address the barriers identified in the previous sections.</p>	<p>Best practices/organization</p>

RSN/PHP REVIEW PROTOCOL 2000- 2001

13. Are there any quality improvement issues that we have not already discussed, or information that you would like to share with us regarding:

- Access to services,
- Acceptability of services
- Consumer satisfaction, or
- Quality of care?

Strengths----

Challenges –

11
B. Via

RSN/PHP REVIEW PROTOCOL

2000-2001

Public Safety

<p>1. How has the Contractor maintained connections with local jails and regional prison administrators to improve strategies to ensure mentally ill persons are served appropriately?</p> <p>Have connections been established and maintained with <u>all</u> of the jails within the region?</p> <p>Have any barriers been encountered or identified?</p> <p>What steps have been taken to address any barriers that may have been identified?</p>	<p>Contract page 21 – 7.1.1</p>
<p>2. What are the results of the crisis line testing?</p> <p>Frequency of crisis line testing by the RSN?</p>	

RSN/PHP REVIEW PROTOCOL
2000-2001

QUALITY MANAGEMENT

1. What efforts and/or progress has the RSN/PHP made with quality improvements issues identified during the last MHD review, is any?	Contract page 21 7.1 1
2. Are the contractors quality management plan specific time frames for implementation, being adhered to? What if any barriers have been encountered?	Federal Waiver page 15 Contract 4.1.1, and Exhibit I, page 1-1

RSN/PHP REVIEW PROTOCOL

2000-2001

<p>3. What evidence or documentation can the Contractor provide to establish that it has implemented an analysis of care provided to at least ten (10) percent or 500 total (if smaller) representative sampling of service recipients on an annual basis?</p> <p>(The following qualify for the 10 % sampling: Chart Reviews, Concurrent reviews, Surveys, Focus Groups, Individual Interviews, Ombuds reviews of complaints or grievances)</p> <p>Estimated number of clients served annually _____</p> <p>Chart reviews _____</p> <p>QRT focused studies conducted _____</p> <p>Concurrent Reviews _____</p> <p>Surveys _____</p> <p>Ombuds Grievances _____</p> <p>Total to date _____</p>	<p>Federal Waiver page 16, and Contract Exhibit I</p>
<p>4. Has the Contractor demonstrated <u>implementation</u> of its analysis of Clinical Care through the following:</p> <ul style="list-style-type: none"> a. The clinical appropriateness or fit between what was needed and what was received b. The degree to which services provided are driven by recipient needs c. The degree to which services and planning incorporate the service recipients voice d. The degree to which services and planning are age, culturally and linguistically competent 	

RSN/PHP REVIEW PROTOCOL
2000-2001

<p>e. The degree to which services are provided in the least restrictive environment</p> <p>f. The degree to which needs for housing, employment and education options were assessed and support and services provided</p> <p>g. The degree to which there was inclusion, recruitment and use of natural supports and other community resources</p> <p>h. The degree to which there are appropriate linkages and integration with other systems and settings</p> <p>i. The degree to which there was congruency between the chart including assessment, treatment plan, and progress notes and the actual services and supports provided</p> <p>j. Performance regarding clinical care are within acceptable ranges</p>	
---	--

RSN/PHP REVIEW PROTOCOL

2000-2001

<p>5. Has the Contractor demonstrated <u>Implementation</u> of its analysis of the service system for:</p> <p>Services for underserved populations are accessible,</p> <p>Services are accessed promptly, geographically accessible, convenient and timely,</p> <p>Without waiting lists for Medicaid recipients,</p> <p>Adequate triage for all settings of care (inpatient, urgent care, and outpatient services and supports)</p>	<p>Federal Waiver page 17 and Exhibit I of Contract</p>
<p>6. Is the PHP's interpretation of the data that is being collected shared with practitioners on a regular basis?</p> <p>What feedback have you received?</p>	<p>Federal Waiver page 24, #4 Contract Exhibit I</p>
<p>7. Has the Contractor performed periodic evaluation(s) of its overall quality management System?</p> <p>What are the results of the last evaluation performed?</p> <p>What system improvements have occurred as a result of this evaluation?</p> <p>Who was involved in this process?</p>	<p>Contract Exhibit I page 1-1 Federal waiver page 16, (h)</p>

RSN/PHP REVIEW PROTOCOL

2000-2001

<p>8. Has the contractor provided an independent review of the quality of care through a process operated by a majority of current or past recipients and their family members?</p> <p>What were the results of this review?</p> <p>How were the results utilized to make system improvements?</p>	<p>Federal waiver page 24, (#3) Contract Exhibit I, page 1-1</p> <p>Note: This independent review may be conducted by the QRI</p>
<p>9. Has the Contractor undertaken any focused studies since the last on-site review to improve/understanding the system of care?</p> <p>If so, what was learned and how was this information utilized to make system improvements?</p>	<p>Exhibit I page 1-1</p>
<p>10. (*) What are the results of the Contractor tracking Complaints and Grievances processes?</p> <p>At what levels are these being tracked?</p> <p>Is there any RSN data which would indicate that the vast majority of complaints/grievances have been made regarding:</p> <ul style="list-style-type: none"> ♦ Consumer Rights, ♦ Access, ♦ Quality of Services, ♦ Service intensity, ♦ Service not available, or ♦ Coordination of services? 	<p>Federal waiver page 16 MHD response to HCFA questions page 36 Q5</p> <p>Note: What we want to know here is, has the resolution of complaints at any level been satisfactory for the consumers?</p>

RSN/PHP REVIEW PROTOCOL

(March 2004)

<p>Note: What we want to know here is, has the resolution of complaints at any level been satisfactory for the consumers?</p>	
<p>11. How are the grievances linked to the quality management system?</p> <p>How has this led to quality improvements?</p>	<p>Federal Waiver page 23</p>
<p>12. (*) At which point and through what means are consumers notified about:</p> <ul style="list-style-type: none"> • changes, • denials, • terminations from service, • or reductions in services available to them, both individually and as a group? <p>What is the RSN's system wide policy and oversight relating to this requirement?</p>	<p>MHD response to HCFA questions (access to services) page 11 (a)</p>
<p>13. (*) Clarify the process through which consumers are provided information about and access to their rights and responsibilities, their right to disenroll.</p> <p>What is known about disenrollments within the RSN?</p> <p>Number of requests?</p> <p>Number of occurrences?</p> <p>Reasons for requests?</p>	<p>Federal Waiver page 19, MHD response to HCFA questions (access to services) page 18 (c)</p> <p>The federal waiver (section N, Client Disenrollment), states: As part of the informal and formal PHP grievance procedures, and through the DSHS Fair Hearing process, if necessary, a recipient may seek disenrollment from a PHP for good cause. Good cause is defined as an inability of the PHP to provide appropriate access or care within the scope of the waiver defined services.</p> <p>It further states, "A recipient may use the grievance process and ombudsperson to seek disenrollment from his/her assigned PHP and enrollment in the neighboring PHP". If a Medicaid service is needed by a recipient and is not provided by the PHP, the recipient may obtain that service with a medical ID card through the usual fee-for-service program</p> <p>In the Washington State HCFA Waiver, Question Responses 1. Access to Services, it states.</p>

RSN/PHP REVIEW PROTOCOL

2000-2001

	<p>"It appears to HCFA, from review of these materials that, at a functional level, the waiver and RSN structure as it is currently implemented, precludes the right of a recipient to disenroll." "It is conceivable, therefore, that instances would occur in which a particular individual's needs could not be met with the services available through the RSN to which they are assigned. In those instances, for those individuals, the disenrollment process must be accessible and functional. they must have an alternative option for receiving the treatment they need."</p> <p>"HCFA needs to be assured that individuals have option of adequate access to a functional disenrollment process in all RSNs and at the State level." (page 14)</p>
<p>14. Quality Management – MIS How does the Contractor attest to the integrity of the management information system data being reported?</p> <p>Does the RSN/PHP perform validation checks of reported information to the source record?</p>	

AGENCY ENTRANCE

NOTE: At the beginning of each agency site visit, the Clinical team will have an entrance meeting with agency leadership and RSN representative(s) for introductions, an overview of the audit process and a more structured discussion format (see attached questions/discussion points). Discussing these questions in a refined entrance process gives the agencies the opportunity to present information that may not otherwise be reflected in the chart reviews and/or case presentations. *Please discuss the following questions within the context of consumers served by your agency.*

CRISIS RESPONSE

1. What changes, if any, have occurred in the crisis services system within your agency since the last review? Are there added values or drawbacks as a result of those changes?
2. How are your crisis services coordinated with the local tribes?
3. What capacities do you have to provide home, community stabilization, and flexible supports across your geographic catchment area?
4. What do you believe are your strengths and weaknesses within your crisis service delivery system?

CLINICAL COMPETENCY

1. What are the primary indicators that you use to understand your clinician workforce competency?
2. How do you assure that specialist consults are occurring?
3. How do you understand the diversity of your service area and ensure cultural competence in staffing?
4. What do you believe are the strengths and weaknesses of your clinical workforce?

INPATIENT UTILIZATION/MANAGEMENT

1. How do you operationalize an active role in treatment and planning regarding inpatient hospitalization?
2. What is your process for linking inpatient, long term residential, crisis, and outpatient services throughout the entire continuum of care?
3. Provide examples of how consumers give feedback regarding their experience with inpatient services? How is the feedback utilized?

Integrated Review Chart Review Methodology

Focus of the chart review The purpose of the chart review is to understand how charts are used in formulating care and documenting progress. The utility of the chart as a strategic clinical tool is also assessed. The overall focus of the chart review process is to understand how the individual consumer's needs are being understood and met by the RSN/PHP. The review will assess the fit between the consumer's needs and the supports being provided. Reviewers will focus on assessment and treatment activities as well as clarity of processes used to develop ongoing support for the individual. The prospective use of the chart to provide comprehensive and strategic planning of care activities will be assessed. Finally, while the work of agencies is reviewed, it is the aggregate information and the overall performance of the RSN/PHP that is being assessed. This is not an agency licensing activity.

Process The chart review is held on site at the agency and is composed of two components utilizing a *revised* Client Record Review Protocol (see attached). As part of the case presentation structure, the chart is reviewed with a focus on assessing the congruency between the presentation and the documentation. The chart therefore needs to be available to the review team so that it can be reviewed during the presentation. The second component consists of a more traditional chart review process. A member of the review team will be working on these chart reviews throughout the day.

Who should be involved? A person who is familiar with the records and the agency operations should be available at the beginning of the chart review process to give the team a brief orientation to the charts. The Clinical Record Review Protocol can be referenced regarding what the team is looking for in charts.

Selection of charts For this review, the RSN/PHP's or its sub-contracted agency will pick one half of the total required charts. There should be approximately equal numbers of children, adults and elderly client charts with at least one-fourth of these being minority. Once on site, the review team will pick the other one-half of the charts.

Chart Review Team Requirements The review team will require a work space large enough for 1-2 people to review charts. It is also helpful to have a listing of the charts identifying who made the selection (agency/RSN) and a list of names of various mental health specialists and clinical supervisor's.

Anyone desiring more information about the Integrated Review processes may contact Jeanne Stevens-Taylor at (360)902-0803.

Revised 8/98

Clinical Review Team - Agency Entrance

At the beginning of each agency site visit, the Clinical Review Team will have an entrance meeting with agency leadership and RSN representative(s) for introductions, an overview of the audit process, and a more structured conversation. Discussing these questions in a refined entrance process gives the agencies the opportunity to present information that may not otherwise be reflected in the chart reviews &/or case presentations.

Follow-Up Discussion

Shortly following the final presentation, the Clinical Review Team will again meet with agency leadership and RSN representative(s) to briefly discuss system questions that surfaced during the clinical presentations. This will provide an opportunity for the review team to take the practical information from the case presentations, charts, and entrance interview to get a clearer understanding of regional operations and functioning.

Entrance Questions

Please discuss the following questions *as they pertain to your agency within the context of the regional provider network*:

OVERVIEW:

1. Please provide a brief thumbnail sketch of your agency and its role in the provider network.

FOLLOW-UP FROM PREVIOUS REVIEW:

1. What changes have occurred in the crisis service system within your agency/regional crisis system since the last review? What has been the impact of those changes? What barriers remain? What is the plan to address these barriers?
2. With the diversity of your service area, how is the agency assuring cultural competence in consultation, staffing, planning, treatment, and discharge planning within your region?
3. What do you believe are the strengths and challenges of your clinical workforce?
4. Within your region's continuum of care, what is your agency's process for linking with inpatient services, long term residential services, and crisis services?

CONSUMER VOICE:

1. How are consumers involved in treatment planning, decision making, and policy setting within your agency?
2. What agency methods (policies/procedures/practices) are used to empower, support, and respect consumers and their supports?
3. How has consumer input/feedback been used to improve/enhance services/systems at the agency level?

CROSS-SYSTEM PARTNERING:

1. How has the RSN promoted and supported your agency to develop flexible/adaptable services that respond to and fit consumers and their supports?
2. How do you promote awareness and active use of allied systems and their resources within your agency? What are some examples of enhancement/improvement in your services as a result? What additional systems/resources are you currently targeting for increased access/involvement?
3. How are cross-system barriers identified and addressed within your agency? Within your region?

QUALITY MANAGEMENT

1. Please give a brief overview of your Quality Management system. Please walk us through one living example of an improvement in your agency directly related to your QM system. In what ways does it align with the RSN's QM process?
2. What are some examples of your agency working with the RSN to solve problems more efficiently and effectively? What are some of the ongoing challenges?

Case Rating

UNDERDEVELOPED <ul style="list-style-type: none"> • In need of substantial change to demonstrate reasonable practices. • Fails to demonstrate satisfactory knowledge of scope and complexity • Does not assure the delivery of competent care. • Does not ensure the provision of quality, consumer responsive, outcome oriented services. 	MINIMUM <ul style="list-style-type: none"> • Demonstrates basic reasonable practice. • Demonstrates basic knowledge of scope and complexity of services needed • Assures the delivery of basic care • Ensures only the basic provision of quality, consumer responsive, outcome oriented services.
STANDARD <ul style="list-style-type: none"> • Demonstrates reasonable practice. • Demonstrates satisfactory knowledge of scope and complexity of services needed. • Assures the delivery of competent care • Ensures the provision of quality, consumer responsive, outcome oriented services. 	EXEMPLARY <ul style="list-style-type: none"> • Demonstrates advanced or creative, and proven practices. • Reflects unequivocal knowledge of scope and complexity of services needed • Includes approaches for reviewing complex clinical conditions. • Well organized, highly manageable, comprehensive, yet targeted. • Ensures the provision of high quality, consumer responsive, outcome oriented services.

Ledge	Conceptualized	Incorporated	Rationale
Voice	Underdeveloped Minimum Standard Exemplary	Underdeveloped Minimum Standard Exemplary	
Focus	Underdeveloped Minimum Standard Exemplary	Underdeveloped Minimum Standard Exemplary	
Pace	Underdeveloped Minimum Standard Exemplary	Underdeveloped Minimum Standard Exemplary	
Normalized	Underdeveloped Minimum Standard Exemplary	Underdeveloped Minimum Standard Exemplary	
Individualized	Underdeveloped Minimum Standard Exemplary	Underdeveloped Minimum Standard Exemplary	
Linkages & Integration	Underdeveloped Minimum Standard Exemplary	Underdeveloped Minimum Standard Exemplary	
Crisis Prevention/Risk	Underdeveloped Minimum Standard Exemplary	Underdeveloped Minimum Standard Exemplary	

Date: ___/___/___

Case Presentation Review Form

RSN: _____

Agency: _____

Client: _____

Population Group (age/cultural minority): _____

Admission Date: _____

Time in service: _____

Expected stay: _____

I. Assessment

HISTORY

Brief psychosocial Hx:

Dx, Tx, and Rx History:

Cultural (age, ethnic, religious, etc.) Context:

CONSUMER NEEDS (stated, identified, underlying)

Identified by Consumer

Identified by Natural Supports (for the consumer and to support the consumer)

Identified by Provider (for the consumer and to support the consumer)

Life Domains:

☐ Housing☐ Social Supports☐ Substance Abuse (consumer/family)☐ ADLs☐ Cultural☐ Physical Health☐ Mental Health☐ Safety☐ Work/Vocational☐ Legal☐ Education☐ Financial

CONSUMER STRENGTHS (stated, identified, underlying)

Identified by Consumer

Identified by Natural Supports (strengths of the consumer and of the supports)

Identified by Provider (strengths of the consumer and of the supports)

Bvld. 1

Individualized Approaches (tailored to "fit" the consumer, strength-based, flexible, responsive, creative)

II. Planning & Treatment

Focus on Normalization (age, gender, environmental, and cultural needs that any similar persons in their community may have)

Crisis Planning/Risk Management (proactive/preemptive planning that monitors and diffuses any potential deterioration or crisis)

III. System Involvement (RSN/PHP, Provider, Formal Systems)

	Strengths/Supports/Resources	Issues/Barriers/Weaknesses
Response to/Support of Consumers		
Resources for this consumer & the larger consumer population		
Partnering, inclusion, and collaborative efforts		

IV. Quality Management

Indicators of Quality Assurance

Indicators of Quality Improvement

INTEGRATED REVIEW - Clinical Outpatient Record Review Protocol

Date: ___/___/___ Agency: _____ RSN: _____

Case ID #: _____ Age: _____ Admission Date: ___/___/___ Time in service: _____

Ethnic/Cultural Minority Status: _____ Disability: _____

CLINICAL CARE - Quality and Intensity Rating Scale

<u>Underdeveloped</u>	<u>Minimum</u>	<u>Standard</u>	<u>Exemplary</u>
<ul style="list-style-type: none"> In need of change to demonstrate reasonable practice Does not demonstrate satisfactory knowledge of scope and complexity Does not assure delivery of adequate care Does not ensure the provision of quality, consumer responsive, outcome oriented services 	<ul style="list-style-type: none"> Demonstrates basic reasonable practice Demonstrates basic knowledge of scope and complexity of services needed Assures delivery of basic care Ensures basic provision of quality, consumer responsive, outcome oriented services 	<ul style="list-style-type: none"> Demonstrates reasonable practice Demonstrates reasonable knowledge of scope and complexity of services needed Assures the delivery of competent care Ensures provision of quality, consumer responsive, outcome oriented services 	<ul style="list-style-type: none"> Demonstrates advanced and/or creative and proven processes Reflects unequivocal knowledge of the scope and complexity of services needed Well organized, highly manageable, comprehensive, yet targeted Ensures the provision of high quality, consumer responsive, outcome oriented services

INTAKE

1. Date of first contact: ___/___/___		
2. Referral Source: _____		
3. Is there clear documentation of referral source expectations?	Yes	No
4. Is there clear documentation of system responsiveness from time of referral to the time of the first contact?	Yes	No
5. Is there clear documentation of system responsiveness from the time of first contact to the first treatment activity?	Yes	No

ASSESSMENT

1. The assessment has been completed within 30 days of initiating community support services. (WAC 275-57-410)	Yes	No
2. Evidence that the provider and consumer or legally responsible other have collaboratively identified consumer's strengths and needs through a full intake evaluation. (WAC 275-57-410)	Yes	No
3. There is clear assessment across key life domains and areas of potential need including:		
a) Housing	Yes	No
b) Activities of Daily Living (ADLs)	Yes	No
c) Social supports	Yes	No
e) Cultural (e.g. ethnic, sexual, rural)	Yes	No
f) Mental health (diagnosis, medication, and treatment)	Yes	No
g) Physical health	Yes	No
h) Safety/crisis plan	Yes	No
i) Substance abuse (consumer and/or family)	Yes	No
j) Work/vocational	Yes	No
k) Education	Yes	No

l) Legal	Yes	No
m) Financial	Yes	No
4. Intake/assessment has included input from family members and other natural support systems, or adequate documentation why this was not possible. (WAC 275-57-410)	Yes	No
5. There is an assessment of other formal systems that are or should be involved in providing ongoing care. (WAC 275-57-410)	Yes	No
6. If Medicaid child and referred by health provider : Child has received a mental health assessment within 30 days of receipt of referral. OR If Medicaid child and NOT referred by a health provider : Child has been referred for EPSDT screen within 30 days.	Yes	No
7. Quality of intake indicators:	Rating Underdeveloped Minimum Standard Exemplary	

PLANNING

1. There is an individualized plan that is developed with the consumer and those who know the consumer best. (WAC 275-57-020)	Yes	No
2. There is an individualized plan that focuses on and enhances consumer strengths as defined by the consumer. (WAC 275-57-020)	Yes	No
3. There is an individualized plan that is flexible and responsive to the consumer's changing needs. (WAC 275-57-020)	Yes	No
4. There is an individualized plan that focuses on meeting those basic needs that persons of similar age, gender, and culture have. (WAC 275-57-020)	Yes	No
5. Does this consumer have a specific Individualized Tailored Care Plan (ITCP)? If "Yes," specify how it was determined: ___ recipient requested ___ case manager/therapist requested ___ ongoing relationship with other formal services ___ otherwise determined by contractor	Yes	No
6. There is a focus on normalization that addresses the needs identified by the consumer which may include: least restrictive housing; income; work or school; social life; treatment including psychotherapy; and services to address the specialized needs of underserved populations. (WAC 275-57-410)	Yes	No

7. For adults, the plan was developed with the consumer to include people who provide active support to the consumer (e.g., family members, etc) at the consumer's request...	Yes	No
OR		
For children, the plan was developed with the child, family and others who provide active support to the child. For children under three, the plan shall be integrated with the Individualized Family Service Plan (IFSP), when applicable. (WAC 275-57-410)		
8. There are clear re-assessments within reasonable timelines with the development of revised and/or new goals.	Yes	No
9. At a minimum, the treatment plan has been mutually reviewed every six months.	Yes	No
10. There is a safety/crisis plan.	Yes	No
11. The crisis plan is reviewed to meet the changing needs every 180 days? (Contract, Exhibit C)	Yes	No
12. There are clear plans/processes identified to address reduction of services and/or discharge while assuring needs continue to be met.	Yes	No
13. Comment on treatment planning indicators that reflect quality and intensity required on this case.	<u>Rating</u> Underdeveloped Minimum Standard Exemplary	

SPECIAL POPULATIONS

1. Is the consumer a member of a special needs population?	Yes	No
If "Yes," specify and continue: ____ child ____ elderly ____ ethnic minority ____ disabled ____ other		
2. There is documentation that an appropriate specialist is involved? (RCW 71.24.045)	Yes	No
3. There is documentation that the specialist has been involved in assessing, planning, treatment reviews, and other critical treatment decisions? (RCW 71.24.045)	Yes	No
4. There is assessment of cross-cultural relations, knowledge and acceptance of dynamics of cultural differences, expansion of cultural knowledge and adaptation of services to meet culturally unique needs. (WAC 275-57-020)	Yes	No

5. Comment on indicators that reflect the quality and intensity necessary to serve this special population consumer:	<u>Rating</u> Underdeveloped Minimum Standard Exemplary
--	---

TREATMENT AND SUPPORTS		
1. There are clear links between assessed needs and treatment/support activities.	Yes	No
2. Services are defined in such a way as to achieve identifiable outcomes.	Yes	No
3. The plan links outcomes to specific goals and time frames.	Yes	No
4. As needed, the staff helps the consumer:		
a) access basic needs in an age and culturally competent manner including: housing; food; income; health and dental care; transportation; (WAC 275-57-420)	Yes	No
b) work or participate in other daily activities appropriate to the consumer's age and culture; (WAC 275-57-420)	Yes	No
c) link with regular social life in the community; (WAC 275-57-420)	Yes	No
d) access other needed services, such as substance abuse counseling and health care; (WAC 275-57-420)	Yes	No
e) resolve crisis in least restrictive settings; (WAC 275-57-420)	Yes	No
f) manage symptoms by providing information and education about the consumer's illness and treatment; (WAC 275-57-420)	Yes	No
g) assist family members and other care givers in their efforts to support and care for the consumer; (WAC 275-57-420)	Yes	No
h) include, as necessary, flexible application of funds, such as rent subsidies, rental deposits, and in-home care to enable stable living in the community, and; (WAC 275-57-420)	Yes	No
i) by providing services where and when needed. (WAC 275-57-420)	Yes	No
5. Services ensure continuity of care. (WAC 275-55-263)	Yes	No
6. There is use of referrals and assistance in obtaining supportive services as appropriate to treatment. (WAC 275-55-263)	Yes	No
7. Those services are coordinated and integrated. (WAC 275-55-263)	Yes	No
8. Comment on treatment and support indicators that reflect the quality and intensity required on this case.	<u>Rating</u> Underdeveloped Minimum Standard Exemplary	

RECORDS/DOCUMENTATION

1. Records are organized in a manner that facilitates clear understanding of needs, goals, and activities of this consumer.	Yes	No
2. Records allow the tracking of consumer progress in achieving treatment goals. (WAC 275-57-410)	Yes	No
3. The records include specific progress toward established goals, changes in individualized plans, and extraordinary events. (WAC 275-57-410)		
4. Records contain sufficient information to establish the need for medically necessary* clinical mental health services.	Yes	No
<i>* A term for describing requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate, or prevent the worsening of conditions in the client that endanger life, or cause suffering or pain, or result in an illness or infirmity, or threat to cause or aggravate a handicap, or cause physical deformity or malfunction, and there is no equally effective, more conservative or substantially less costly course of treatment available or suitable for the client requesting the service. For the purpose of this section, "course of treatment" may include mere observation or, where appropriate, no treatment at all. (WAC 388-500-0005)</i>		
5. A mental health professional has reviewed and signed off on the intake evaluation, individual plan, and revisions to the individualized plan. (WAC 275-57-410)	Yes	No

OVERALL SUMMARY AND IMPRESSIONS

Do you have any additional comments on this file?

Do you have any concerns or suggestions regarding documentation or actual care to this individual?

This is to certify that the above client record was reviewed by the undersigned during the course of this medical audit.

Reviewer Signature

Date

AGENCY/ORGANIZATIONAL Quality and Intensity Rating Scale

Date:

Agency:

RSN:

Case #s

<u>UNDERDEVELOPED</u>	<u>MINIMUM</u>	<u>STANDARD</u>	<u>EXEMPLARY</u>
<ul style="list-style-type: none"> • In need of substantial change to demonstrate reasonable practices. • Fails to demonstrate satisfactory knowledge of scope and complexity. • Does not assure the delivery of competent care. • Does not ensure the provision of quality, consumer responsive, outcome oriented services. 	<ul style="list-style-type: none"> • Demonstrates basic reasonable practice. • Demonstrates basic knowledge of scope and complexity of services needed. • Assures the delivery of basic care. • Ensures only the basic provision of quality, consumer responsive, outcome oriented services. 	<ul style="list-style-type: none"> • Demonstrates reasonable practice. • Demonstrates satisfactory knowledge of scope and complexity of services needed. • Assures the delivery of competent care. • Ensures the provision of quality, consumer responsive, outcome oriented services. 	<ul style="list-style-type: none"> • Demonstrates advanced or creative, and proven practices. • Reflects unequivocal knowledge of scope and complexity of services needed. • Includes approaches for reviewing complex clinical conditions. • Well organized, highly manageable, comprehensive, yet targeted. • Ensures the provision of high quality, consumer responsive, outcome oriented services.

ACCESS - Ensures access to the full range of services provided within the service area. Equal access includes demonstrated availability of qualified personnel to provide a full range of age, culturally, and linguistically appropriate services. Services available promptly, geographically accessible, and are convenient and timely and without waiting lists.

conceptualized: underdeveloped minimum standard exemplary

incorporated: underdeveloped minimum standard exemplary

Indicators _____

ADDRESSING BARRIERS - Ability to identify any obstacles in the agency, system, or community that detract and/or inhibit the highest quality of service delivery and actively develop a plan to overcome.

conceptualized: underdeveloped minimum standard exemplary

incorporated: underdeveloped minimum standard exemplary

Indicators _____

CROSS-SYSTEM INTEGRATION - Active "team" work that includes joint planning and implementation of services with ongoing established communication and the ability to respond quickly and in a coordinated manner to both crisis and changes. The facilitation of the continuum of care and treatment.

conceptualized: underdeveloped minimum standard exemplary

incorporated: underdeveloped minimum standard exemplary

Indicators _____

<u>UNDERDEVELOPED</u>	<u>MINIMUM</u>	<u>STANDARD</u>	<u>EXEMPLARY</u>
<ul style="list-style-type: none"> • In need of substantial change to demonstrate reasonable practices. • Fails to demonstrate satisfactory knowledge of scope and complexity • Does not assure the delivery of competent care. • Does not ensure the provision of quality, consumer responsive, outcome oriented services. 	<ul style="list-style-type: none"> • Demonstrates basic reasonable practice. • Demonstrates basic knowledge of scope and complexity of services needed • Assures the delivery of basic care • Ensures only the basic provision of quality, consumer responsive, outcome oriented services. 	<ul style="list-style-type: none"> • Demonstrates reasonable practice. • Demonstrates satisfactory knowledge of scope and complexity of services needed. • Assures the delivery of competent care • Ensures the provision of quality, consumer responsive, outcome oriented services. 	<ul style="list-style-type: none"> • Demonstrates advanced or creative, and proven practices. • Reflects unequivocal knowledge of scope and complexity of services needed • Includes approaches for reviewing complex clinical conditions. • Well organized, highly manageable, comprehensive, yet targeted. • Ensures the provision of high quality, consumer responsive, outcome oriented services.

CULTURAL COMPETENCE – A set of congruent behaviors, attitudes, and policies that come together in a system or agency and enable that system or agency to work effectively in cross-cultural situations. A culturally competent system of care acknowledges and incorporates, at all levels, the importance of language and culture, assessment of cross-cultural relations, knowledge and acceptance of dynamics of cultural differences, expansion of cultural knowledge and adaptation of services to meet culturally unique needs.

conceptualized: underdeveloped minimum standard exemplary

incorporated: underdeveloped minimum standard exemplary

Indicators _____

FLEXIBILITY – Services that are offered in convenient locations (e.g. homes, out of facility) to the service recipient and are responsive to the needs, in the least restrictive manner, allowing the greatest possibility for recovery in normalized living. Services and supports are developed creatively to meet the unique needs of the consumer, and are not hindered by categorically defined services or programs.

conceptualized: underdeveloped minimum standard exemplary

incorporated: underdeveloped minimum standard exemplary

Indicators _____

PROFESSIONAL DEVELOPMENT – Training and educational opportunities that enhance, supplement, and reinforce quality clinical and system functioning. Clinical supervision, specialist involvement, and consultation are intentionally integrated into the education and improvement of clinical services.

conceptualized: underdeveloped minimum standard exemplary

incorporated: underdeveloped minimum standard exemplary

Indicators _____

RSN/PHP Clinical Care Composite Rating

Date _____ RSN/PHP _____ Agency _____ Case # _____

UNDERDEVELOPED	MINIMUM	STANDARD	EXEMPLARY
Does not meet expectations... <ul style="list-style-type: none"> ❖ Does not assure delivery of adequate care ❖ In need of change to demonstrate reasonable practice ❖ Does not demonstrate satisfactory knowledge of scope and complexity ❖ Does not ensure provision of quality, consumer responsive services 	Meets minimum expectations... <ul style="list-style-type: none"> ❖ Assures delivery of basic care ❖ Demonstrates basic reasonable practice ❖ Demonstrates basic knowledge of scope and complexity of service needed ❖ Ensures basic provision of quality, consumer responsive services 	Meets expectations... <ul style="list-style-type: none"> ❖ Demonstrates reasonable practice ❖ Demonstrates clear knowledge of scope and complexity of services needed ❖ Assures the delivery of competent care ❖ Ensures provision of quality, consumer responsive, outcome-oriented services 	Exceeds expectations... <ul style="list-style-type: none"> ❖ Demonstrates advanced and/or creative and proven processes ❖ Reflects unequivocal knowledge of the scope and complexity of services needed ❖ Well organized, highly manageable, comprehensive, yet targeted ❖ Ensures the provision of high quality, consumer responsive, outcome oriented services

RSN/PHP Themes	Rating	Rationale
<i>Acceptability of services</i>	Underdeveloped Minimum Standard Exemplary	
<i>Quality of Care</i>	Underdeveloped Minimum Standard Exemplary	

Indicators	U	M	S	E	Rationale
<i>The degree to which services provided were driven by recipient needs (incl. housing, employment, education, etc.)</i>					
<i>The degree to which services and planning incorporate service recipient's voice</i>					
<i>The clinical appropriateness or "fit" between what was needed and what was received</i>					
<i>The degree to which services and planning are age, culturally, linguistically competent</i>					
<i>The degree to which there is inclusion, recruitment, and use of natural supports and other community resources</i>					
<i>The degree to which there are appropriate linkages and integration with other systems and settings</i>					
<i>The degree to which services are provided in the least restrictive environment</i>					
<i>The degree to which there is congruency between the chart (assessment, treatment plan, progress notes) and the actual services and supports provided</i>					

Integrated Review Case Rating - Case # _____

UNDERDEVELOPED - Does not meet expectations... <ul style="list-style-type: none"> ❖ Does not assure delivery of adequate care ❖ In need of change to demonstrate reasonable practice ❖ Does not demonstrate satisfactory knowledge of scope and complexity ❖ Does not ensure provision of quality, consumer responsive services 	MINIMUM - Meets minimum expectations... <ul style="list-style-type: none"> ❖ Assures delivery of basic care ❖ Demonstrates basic reasonable practice ❖ Demonstrates basic knowledge of scope and complexity of service needed ❖ Ensures basic provision of quality, consumer responsive services
STANDARD - Meets expectations... <ul style="list-style-type: none"> ❖ Demonstrates reasonable practice ❖ Demonstrates clear knowledge of scope and complexity of services needed ❖ Assures the delivery of competent care ❖ Ensures provision of quality, consumer responsive, outcome-oriented services 	EXEMPLARY - Exceeds expectations... <ul style="list-style-type: none"> ❖ Demonstrates advanced and/or creative and proven processes ❖ Reflects unequivocal knowledge of the scope and complexity of services needed ❖ Well organized, highly manageable, comprehensive, yet targeted ❖ Ensures the provision of high quality, consumer responsive, outcome oriented services

RSN/PHP Themes	Rating	Rationale
Acceptability of services	Underdeveloped Minimum Standard Exemplary	
Quality of Care	Underdeveloped Minimum Standard Exemplary	

INDICATORS	A	B	C	D	Rationale
The degree to which services provided were driven by recipient needs (incl. housing, employment, education, etc.)					
The degree to which services and planning incorporate service recipient's voice					
The clinical appropriateness or "fit" between what was needed and what was received					
The degree to which services and planning are age, culturally, linguistically competent					
The degree to which there is inclusion, recruitment, and use of natural supports and other community resources					
The degree to which there are appropriate linkages and integration with other systems and settings					
The degree to which services are provided in the least restrictive environment					
The degree to which there is congruency between the initial assessment, treatment plan, progress notes and the actual services and supports provided					

Clinical Review - Daily Summaries

RSN: _____

Reviewer: _____

Date: ____/____/____

Agency: _____

Role: charts/case presentations/both (circle one)

Strengths/Issues Regarding Consumer Voice:

Strengths/Issues Regarding Cross-systems:

Strengths/Issues Regarding Quality Management (RSN/PHP/Provider roles & resources)

Acceptability of services:

Quality of Care:

Other Themes:

3.1

Date: __/__/__ Agency: _____ Role: charts/case presentations/both (circle one)

Strengths/Issues Regarding Consumer Voice:

Strengths/Issues Regarding Cross-systems:

Strengths/Issues Regarding Quality Management (RSN/PHP/Provider roles & resources)

Acceptability of services:

Quality of Care:

Other Themes:

FLAG SHEET - Clinical Review

Agency: _____

RSN: _____

Date: __/__/__

List any questions or concerns that surface from the charts or case presentations that may facilitate further dialogue with agency leadership &/or RSN representatives that would help to better understand the regional structure, functions, or operations.

Case/Chart	Question/Concern	Agency/RSN Response	Reviewer Note/Summary
Case/Chart	Question/Concern	Agency/RSN Response	Reviewer Note/Summary
Case/Chart	Question/Concern	Agency/RSN Response	Reviewer Note/Summary
Case/Chart	Question/Concern	Agency/RSN Response	Reviewer Note/Summary

BV10.17

Case/Chart	Question/Concern	Agency/RSN Response	Reviewer Note/Summary
Case/Chart	Question/Concern	Agency/RSN Response	Reviewer Note/Summary
Case/Chart	Question/Concern	Agency/RSN Response	Reviewer Note/Summary
Case/Chart	Question/Concern	Agency/RSN Response	Reviewer Note/Summary
Case/Chart	Question/Concern	Agency/RSN Response	Reviewer Note/Summary

INSTRUCTIONS

The Provider Agency Self Evaluation and State Licensing Survey Tool is a dual purpose document designed to be employed by all licensed mental health provider agencies in an internal self evaluation of compliance with statewide standards as expressed in WAC 275-57. It will also be used by the Licensing Section of the Mental Health Division in determining the extent to which provider agencies meet licensing requirements.

SURVEY TOOL FORMAT EXPLANATION:

LICENSING STANDARD #	WAC SECTION/WAC PROVISION	SOURCE OF DOCUMENTATION (AGENCY REF)	DOCUMENTATION FINDING	OPERATIONAL IMPLEMENTATION FINDING
-------------------------	------------------------------	--	--------------------------	--

The provider agency shall identify the source of documentation for each license standard (WAC Provision) e.g., personnel file, consumer record and page of policy manual, etc. When doing the survey the reviewer shall enter either a C-for full compliance, a D-for Deficiency or an M-for missing documentation in both the documentation column and the implementation column thereby indicating the quality of the documentation and also the quality of the implementation of standards. This internal self evaluation should be done annually and result in corrective actions to be performed as required. Copies of the most recent self evaluation and records of corrective actions required and completed must be retained in agency files. It is expected a consumer/advocate survey be done at least annually for improvement in services. Upon completion of the self-evaluation survey and the consumer/advocate survey, agency Directors shall review, approve and sign the document prior to furnishing a copy of it and any resultant corrective actions to the Chair of the agency board of directors who, in turn, are to review, approve and sign the document.

Please note that the shaded areas will not be reviewed on site by the Licensing and Certification Section. Self evaluation is still required and standards may be reviewed by other Mental Health Division, Department of Social and Health Services, or other state agencies entities.

When the Licensing & Certification Section of the State Mental Health Division performs its licensing review, it will use the most recent completed provider agency self evaluation document in the same manner as described for the provider above.

Bua

PROVIDER AGENCY
SELF EVALUATION AND LICENSING SURVEY TOOL

Provider: _____

RSN/County: _____

Provider Reviewer: _____ Date: _____

QA Reviewer: _____ Date: _____

Review Materials Needed:

- * The detailed plan for the operation of agency services
- * RSN accounting and auditing procedures for agencies contracting with RSNs and related documentation e.g., budget, independent audit accounting records
- * RSN/Agency contract and agency sub-contracts
- * Telephone listings
- * Service brochures and materials describing services
- * Ombuds service information
- * RSN admission, placement, transfer and discharge criteria for both adults and children
- * Management information report requirements
- * Sliding fee schedule
- * Quality Assurance program description and records
- * Personnel records (including medical staff)

- * List of mental health professional, specialists and consultants with signatures
- * Training records and plans
- * Clinical supervision records
- * Staff evaluation records
- * Affirmative action program description
- * Copy of voluntary consumer rights statement (include the right to a second opinion (Section 240) and the right to change primary care provider (Section 210) for PHPs)
- * Grievance records
- * Agency program service descriptions for licensed services
- * Medication inventory records
- * List of agency facilities

I CERTIFY THAT I HAVE REVIEWED AND APPROVE THIS AGENCY'S SELF-EVALUATION

Signature: _____ Date: _____
 Agency Director

Signature: _____ Date: _____
 Agency Board Chair

WAC 275-56-100 - AWARENESS OF SERVICES.

LICENSE STANDARD #	WAC SECTION/WAC PROVISION	SOURCE OF DOCUMENT	DOCUMENTATION SUITABLE	IMPLEMENTATION
	The RSN, or <u>its designee</u> , shall; (agency licensing standard if delegated in contract by RSN)			
1	(1) Maintain listings of services in telephone and other public directories of the service area. The RSN, or its designee shall prominently display listings for crisis services in telephone directories;			
2	(2) Publish and disseminate brochures and other materials or methods for describing services and hours of operation that are appropriate for all individuals, including those who may be visually impaired, limited-English proficient, or unable to read;			
3	(3) Post and make information available to consumers regarding the ombuds service, under Section 160 of this Chapter, and local advocacy organizations that may assist consumers in understanding their rights.			

COMMENTS AND RECOMMENDATIONS: _____

WAC 275-57-120 - MANAGEMENT INFORMATION

LICENSE STANDARD #	WAC SECTION/WAC PROVISION	SOURCE OF DOCUMENT	DOCUMENTATION SUITABLE	IMPLEMENTATION
4	<p>RSN <u>and their subcontractors</u> shall report required management information to the department. To this end, the RSN shall operate an information system and ensure information for persons receiving mental health services funded by public dollars is reported to the state mental health information system, according to departmental guidelines.</p> <p>(1) The department and the RSN shall use the mental health information system for state-wide and/or RSN management reports and for locating case managers.</p>			
5	<p>(2) The department, RSN, <u>and provider</u> shall maintain confidentiality of information contained in the mental health information system according to this chapter and chapters 70.02, 71.05 and 71.34 RCW.</p>			
6	<p>(a) The RSN shall ensure all RSN, county, or <u>provider staff</u> having access to the mental health information systems are instructed in the confidentiality requirements.</p>			
7	<p>(b) The RSN, county, or <u>provider shall maintain</u> on file a statement signed by the staff acknowledging understanding and agreement to abide by these requirements.</p> <p>(c) The department shall ensure violation of confidentiality of information shall result in appropriate disciplinary or civil action, as described in chapter 71.05 RCW.</p>			

COMMENTS AND RECOMMENDATIONS: _____

WAC 275-57-290 - LICENSED SERVICE PROVIDERS - WRITTEN SCHEDULE OF FEES

LICENSE STANDARD #	WAC SECTION/WAC PROVISION	SOURCE OF DOCUMENT	DOCUMENTATION SUITABLE	IMPLEMENTATION
8	<p>The provider shall ensure consumers receive necessary mental health services, regardless of ability to pay the full rate.</p> <p>(1) The provider, excepting services also licensed under chapters 248-14, 246-325 WAC, shall establish and use a sliding fee schedule approved by the department and based on the resources available to the consumer to pay for mental health services and the provider's actual cost of care.</p> <p>(2) The department shall only approve sliding scale fee schedules not requiring payment from consumers with income levels equal to or below the grant standards for the general assistance program, as required under chapter 388-29-100 WAC.</p>			
9	<p>(3) A provider shall ensure the fee schedule is posted and accessible to the provider's staff and consumers.</p>			
10	<p>(4) A provider not contracting with an RSN or PHP shall maintain a sliding fee schedule in accordance with subsections (1) and (3) of this section.</p>			

COMMENTS AND RECOMMENDATIONS: _____

WAC 275-57-300 - LICENSED SERVICE PROVIDERS - QUALITY ASSURANCE

LICENSE STANDARD #	WAC SECTION/WAC PROVISION	SOURCE OF DOCUMENT	DOCUMENTATION SUITABLE	IMPLEMENTATION
11	<p>A provider shall maintain an internal process to improve quality of care.</p> <ul style="list-style-type: none"> (1) A provider shall develop and implement a quality assurance process which: <ul style="list-style-type: none"> (a) Provides for at least an annual review of each staff member providing direct services, considering any complaints or grievances against the person; (b) Reviews all serious incidents; (c) Assesses the quality of intake evaluations; and (d) Assesses the extent to which medications are effectively prescribed. (2) A person providing mental health services shall not review their own work. (3) A provider shall use collected data to correct deficiencies and improve services. 			

COMMENTS AND RECOMMENDATIONS: _____

WAC 275-57-310 - LICENSED SERVICE PROVIDERS - STAFF QUALIFICATIONS

LICENSE STANDARD #	WAC SECTION/WAC PROVISION	SOURCE OF DOCUMENT	DOCUMENTATION SUITABLE	IMPLEMENTATION
	A provider shall employ and retain respectful, competent staff. The provider shall:			
12	(1) Require that all clinical services be provided by a mental health professional or under the clinical supervision of a mental health professional as defined under section 020 of this chapter. The supervisor shall have two years' experience working with priority populations;			
13	(2) Maintain job descriptions with qualifications for each position. Staff shall have education, experience, or skills relevant to the job requirements;			
14	(3) Assure staff providing clinical services be, at a minimum, registered counselors under chapter 18.19 RCW.			
15	(4) Conduct a Washington State Patrol background check and reference check on all staff providing direct services;			

16	<p>(5) Orient direct service staff with less than one year's experience in providing community support services in skills pertinent to the position and the population served.</p> <p>(a) The provider shall include training in:</p> <ul style="list-style-type: none"> (i) Characteristics of severe and persistent mental illness; (ii) Effective age and culturally competent community support interventions relevant to the population served; (iii) Psychopharmacology; (iv) Advocacy and linking consumers to community resources; (v) Working with and supporting families; (vi) For staff providing crisis response services under section 390 of this chapter: crisis intervention and managing assaultive/suicidal behavior; and (vii) For staff providing vocational services under section 440 of this chapter: training in vocational assessment and concepts of supported employment. <p>(b) Persons providing direct services to consumers shall complete this orientation within three months of employment. However, the RSN may waive the requirement for orientation in specific topics when the staff person can provide documentation to the RSN demonstrating training, knowledge, or experience in the waived topics.</p>			
----	---	--	--	--

WAC 275-57-310 - LICENSED SERVICE PROVIDERS - STAFF QUALIFICATIONS - (CONTINUED)

LICENSE STANDARD #	WAC SECTION/WAC PROVISION	SOURCE OF DOCUMENT	DOCUMENTATION SUITABLE	IMPLEMENTATION
17	<p>(6) Provide annual training and staff development under an individualized training plan with time frames for each direct service staff person in the skills pertinent to the position and the population served. Such training includes consumers, families and community members as trainers. At minimum, the provider shall make training available in the following topics:</p> <ul style="list-style-type: none"> (a) Effective community support interventions; (b) Providing individualized, needs-driven planning and services; (c) Providing services responsive to the unique needs of underserved populations and other special populations. Examples of special populations are persons with mental illness who: <ul style="list-style-type: none"> (i) Use high amounts of hospital services; (ii) Receive services from multiple systems; (iii) Are sexual minorities; (iv) Abuse substances; (v) Have a developmental disability; (vi) Are homeless; and (vi) Have AIDS or who are HIV positive. (d) Psychopharmacology; (e) Ethical behavior, including professional conduct and confidentiality. 			

18	(7) Provide regular supervision. Supervision may include routine team case reviews; and			
19	(8) Conduct staff evaluations, at least annually.			

COMMENTS AND RECOMMENDATIONS:

WAC 275-57-320 - LICENSED SERVICE PROVIDERS - QUALIFICATIONS APPROPRIATE TO THE NEEDS OF THE CONSUMER POPULATIONS

LICENSE STANDARD #	WAC SECTION/WAC PROVISION	SOURCE OF DOCUMENT	DOCUMENTATION SUITABLE	IMPLEMENTATION
	The clinical qualifications of persons providing and/or supervising clinical services shall reflect the diverse needs of the consumer populations.			
20	<p>(1) Child Mental Health Specialist. The provider shall ensure services directed to children are provided by, under the supervision of, or with consultation from a child mental health specialist defined as:</p> <p>(a) A mental health professional having completed a minimum of one hundred actual hours (not quarter or semester hours) of specialized training devoted to:</p> <p>(i) The study of child development; and</p> <p>(ii) The treatment of seriously disturbed children and their families.</p> <p>(b) Having the equivalent of one year of full-time experience in the treatment of seriously emotionally disturbed children and their families under the supervision of a child mental health specialist.</p>			
21	<p>(2) Geriatric Mental Health Specialist. The provider shall ensure services directed to the elderly are provided by, under the supervision of, or with consultation from a geriatric mental health specialist defined as:</p> <p>(a) A mental health professional having completed a minimum of one hundred actual hours (not quarter or semester hours) of specialized training devoted to the problems and treatment of the elderly; and</p> <p>(b) Having the equivalent of one year of full-time experience in the treatment of the elderly, under the supervision of a geriatric mental health specialist.</p>			

22	<p>(3) Ethnic Minority Mental Health Specialist. The provider shall ensure services directed to ethnic minority consumers are provided by, under the supervision of, or with consultation from an ethnic minority mental health specialist defined as:</p> <p>(a) A mental health professional having the equivalent of one year of full-time experience in the treatment of consumers in the ethnic minority group served; and</p> <p>(b) Demonstrating cultural competence attained through major commitment, ongoing training, experience or specialization in serving ethnic minorities. In assessing such commitment, the department shall consider whether the individual meets two or more of the following:</p> <ul style="list-style-type: none"> (i) Evidence of one year of service specializing in serving the ethnic minority group under the supervision of an ethnic minority mental health specialist; (ii) Evidence of support from the ethnic minority community attesting to the person's commitment to service to that community; (iii) Citations of specific examples of the person's competence; or (iv) Having completed a minimum of one hundred actual hours (not quarter or semester hours) of specialized training devoted to ethnic minority issues and treatment of ethnic minority consumers. 			
----	--	--	--	--

WAC 275-57-320 - STAFF QUALIFICATIONS APPROPRIATE TO OUR NEEDS OF CONSUMER POPULATION (CONTINUED)

LICENSE STANDARD #	WAC SECTION/WAC PROVISION	SOURCE OF DOCUMENT	DOCUMENTATION SUITABLE	IMPLEMENTATION
23	<p>(4) Disability Mental Health Specialist. The provider shall ensure services directed to consumers with a disability shall be provided by, under the supervision of, or with consultation from a mental health specialist with special expertise in working with that disabled group.</p> <p>(a) If the consumer is deaf, the specialist shall be a mental health professional knowledgeable of deaf culture and psychosocial problems, and able to communicate fluently in the preferred language system of the consumer.</p> <p>(b) The specialist for consumers with developmental disabilities shall be a mental health professional who:</p> <p>(i) Has a least one year's experience with people with developmental disabilities; or</p> <p>(ii) Is a developmental disabilities professional.</p>			

COMMENTS AND RECOMMENDATIONS: _____

WAC 275-57-330 - PERSONNEL MANAGEMENT - AFFIRMATIVE ACTION

LICENSE STANDARD #	WAC SECTION/WAC PROVISION	SOURCE OF DOCUMENT	DOCUMENTATION SUITABLE	IMPLEMENTATION
	The provider shall have an affirmative action program complying with:			
24	(1) The Equal Pay Act of 1963; (2) Title VII of the Civil Rights Act of 1964; (3) Section 504 of the 1974 Rehabilitation Act; (4) The Americans with Disabilities Act; (5) The department's affirmative action guidelines; and (6) Other applicable federal, state, and local laws and regulations.			

COMMENTS AND RECOMMENDATIONS: _____

WAC 275-57-340 CONSUMER RIGHTS

LICENSE STANDARD #	WAC SECTION/WAC PROVISION	SOURCE OF DOCUMENT	DOCUMENTATION SUITABLE	IMPLEMENTATION
	The provider shall ensure consumers are knowledgeable of and protected by certain rights.			
25	(1) The provider shall ensure consumers, prospective consumers, and/or legally responsible others are verbally informed, in their primary language, of consumer rights at admission to brief intervention and community support services.			
26	(2) The provider shall post a written statement of consumer rights in public areas, with a copy available to consumers on request. Providers of only telephone services (e.g., crisis lines) shall post the statement of consumer rights in a location visible to staff and volunteers during working hours.			

27	<p>(3) The provider shall ensure the statement of consumer rights incorporates the following statement or a variation approved by the department: "You have the right to:</p> <ul style="list-style-type: none"> (a) Be treated with respect and dignity; (b) Develop a plan of care and services which meets your unique needs; (c) Refuse any proposed treatment, consistent with the requirements in the Involuntary Treatment Acts, Chapters 71.05 and 71.34 RCW; (d) Receive care which does not discriminate against you, and is sensitive to your gender, race, national origin, language, age, disability, and sexual orientation; (e) Be free of any sexual exploitation or harassment; (f) Review your case record; (g) Receive an explanation of all medications prescribed, including expected effect and possible side effects; (h) Confidentiality, as described in relevant statutes (Chapters 70.02, 71.05 and 71.34 RCW) and regulations (Chapters 275-54 and 275-55 WAC and this Chapter); and (i) Lodge a complaint with the ombuds persons, RSN or provider if you believe your rights have been violated. If you lodge a complaint or grievance, you shall be free of any act of retaliation. The Ombuds persons may, at your request, assist you in filing a grievance. The Ombuds person's phone number is: _____." 			
----	---	--	--	--

	<p>As well as the right to choose a primary care provider pursuant to WAC 275-57-110(5) and . . .</p> <p>In a PHP:</p> <ul style="list-style-type: none"> (a) The right to request an exemption from enrollment in the PHP pursuant to WAC 275-57-200. (b) The right to change primary care providers pursuant to WAC 275-57-210(4) (c) The right to a second opinion from other staff in the recipient's assignee PHP pursuant to WAC 275-57-240; and (d) The right to request disenrollment from the PHP pursuant to WAC 275-57-250. 			

COMMENTS AND RECOMMENDATIONS: _____

WAC 275-57-350 - CONSENT TO TREATMENT AND ACCESS TO RECORDS

LICENSE STANDARD #	WAC SECTION/WAC PROVISION	SOURCE OF DOCUMENT	DOCUMENTATION SUITABLE	IMPLEMENTATION
	This section defines the conditions for informed consent to treatment and enables a consumer to access a consumer's own records. To this end, the RSN and licensed providers shall protect and ensure the rights of all consumers and former consumers.			
28	(1) Any minor over twelve years of age may request and receive treatment without consent of the minor's parents. Parental consent for evaluation and treatment services shall not be necessary in the case of a child referred by child protective services or other public agency because of physical, sexual, or psychological abuse or neglect by a parent or parent surrogate.			
29	(2) The department, RSN, PHP, or provider shall presume an adult is competent to consent to treatment unless otherwise established.			
30	(3) When the consumer, or the consumer's legally responsible other, requests review of case records, the provider shall: (a) Grant the request within seven days, unless the provider knows or has reason to believe the parent or parent surrogate has been a child abuser or might otherwise harm the child; (b) Review the case record in order to identify and remove any material confidential to another person; (c) Allow the consumer sufficient time and privacy to review the record. At the request of the consumer, a clinical staff member shall be available to answer questions; (d) Permit persons requested by the consumer to also be present; and (e) Assess a reasonable and uniform charge for reproduction, if so desired.			

31	<p>(4) The department, RSN, PHP or provider shall obtain written, informed consent of the consumer or legally responsible other before:</p> <ul style="list-style-type: none"> (a) Use of medication; (b) Use of unusual diagnostic or treatment procedures; (c) Use of audio and/or visual device to record the consumer's behavior; and (d) The consumer serves as a subject for research. 			
----	--	--	--	--

COMMENTS AND RECOMMENDATIONS: _____

WAC 275-57-360 - SERVICES ADMINISTRATION - CONFIDENTIALITY OF CONSUMER INFORMATION

LICENSE STANDARD #	WAC SECTION/WAC PROVISION	SOURCE OF DOCUMENT	DOCUMENTATION SUITABLE	IMPLEMENTATION
32	<p>The RSN, PHP, and <u>provider</u> shall ensure information about person consumers not be shared or released except as specified under statute and rule.</p> <p>The RSN <u>and the provider</u> shall protect the confidentiality of all information relating to consumers or former consumers under all confidentiality requirements as defined in Chapters 70.02, 71.05, and 71.34 RCW.</p>			

COMMENTS AND RECOMMENDATIONS:

WAC 275-57-370 - RESEARCH - REQUIREMENTS

LICENSE STANDARD #	WAC SECTION/WAC PROVISION	SOURCE OF DOCUMENT	DOCUMENTATION SUITABLE	IMPLEMENTATION
33	(1) The RSN, PHP, or provider shall conduct research involving human subjects in accordance with 45 CFR, Part 36, Protection of Human Subjects.			
34	(2) An institutional review board (IRB), as defined in chapter 70.02.010 RCW, shall review and approve research prior to contact with subjects.			
35	(3) The RSN, PHP, or provider shall ensure disclosure of patient records without written consent adheres to requirements in Chapters 42.48, 70.02, 71.05.390, 71.05.630, and 71.34 RCW.			
36	(4) The RSN, PHP, or provider shall require certification that proposed research has IRB approval before allowing research activities to commence.			

COMMENTS AND RECOMMENDATIONS: _____

WAC 276-57-380 - LICENSED SERVICE PROVIDERS - ACCESSIBILITY

LICENSE STANDARD #	WAC SECTION/WAC PROVISION	SOURCE OF DOCUMENT	DOCUMENTATION SUITABLE	IMPLEMENTATION
	The provider shall ensure services are easily accessible to consumers. The provider shall make services readily accessible to consumers when and where they are needed and shall reduce or eliminate barriers to service. The provider shall ensure:			
37	(1) Facilities in which services are provided comply with the American with Disabilities Act;			
38	(2) Services are compatible with the culture and in the language of ethnic minority consumers where a significant ethnic minority population, as defined by department guidelines, exists in the RSN;			
39	(3) Alternative service delivery models are provided, where possible, to enhance utilization by underserved groups;			
40	(4) Access to TDD or other telecommunication device or service, and certified interpreters for deaf or hearing impaired consumers; and			
41	(5) Services are brought to the consumer or located at sites where transportation is available to consumers			

COMMENTS AND RECOMMENDATIONS: _____

WAC 275-57-390 - CRISIS RESPONSE SERVICES

LICENSE STANDARD #	WAC SECTION/WAC PROVISION	SOURCE OF DOCUMENT	DOCUMENTATION SUITABLE	IMPLEMENTATION
	The RSN, <u>or its designee</u> , shall provide an integrated crisis response system (CRS) twenty-four-hours-a-day and seven-days-a-week, serving persons of all ages and cultures in crisis. When direct intervention is necessary, the RSN shall, when possible, bring services directly to the person in crisis, stabilizing and supporting the person until the crisis is resolved or a referral made. The RSN shall			
42	(1) Provide telephone screening which: (a) Includes a prominently displayed phone number in the emergency and white page sections of the local phone directory; (b) Ensures all phone calls are answered by people and not recordings; and (c) Limits busy signals			

43	<p>(2) Ensure the least restrictive resolution of the crisis by providing the following services twenty-four-hours-a-day and seven-days-a-week:</p> <ul style="list-style-type: none"> (a) Initial screening and assessment to determine: <ul style="list-style-type: none"> (i) Whether the crisis has a mental disorder basis; and (ii) Course of action to resolve the crisis. (b) Mobile outreach to: <ul style="list-style-type: none"> (i) Conduct face-to-face evaluations; and (ii) Provide in-home or in-community stabilization services, including flexible supports to the person where the person lives. The CRS shall continuously provide stabilization services until the crisis is resolved or a referral made. (c) Access to: <ul style="list-style-type: none"> (i) Medical services, including: <ul style="list-style-type: none"> (A) Emergency medical services; (B) Preliminary screening for organic disorders; (C) Prescription services; and (D) Medication administration (ii) Interpretative services enabling staff to communicate with persons who are limited English proficient; (iii) Voluntary and involuntary psychiatric Inpatient are Chapters 71.05 and 71.34 RCW; and (iv) Other needed resources (d) Investigation and detention services (Chapters 71.05 and 71.34 RCW). 			
44	<p>(3) Engage family, significant others, and other relevant treatment providers as necessary to provide support to the person in crisis.</p>			

WAC 275-57-390 - CRISIS RESPONSE SERVICE (CONTINUED)

LICENSE STANDARD #	WAC SECTION/WAC PROVISION	SOURCE OF DOCUMENT	DOCUMENTATION SUITABLE	IMPLEMENTATION
45	(4) Document all telephone and face-to-face contacts to includes; (a) Source of referral (b) Nature of crisis (c) Time elapsed from initial contact to response; and (d) Outcomes, including: (i) Decision not to respond in person, if applicable; (ii) Follow-up; and (iii) Referrals made			

COMMENTS AND RECOMMENDATIONS: _____

WAC 275-57-400 - BRIEF INTERVENTION SERVICES

LICENSE STANDARD #	WAC SECTION/WAC PROVISION	SOURCE OF DOCUMENT	DOCUMENTATION SUITABLE	IMPLEMENTATION
	The provider shall implement a streamlined process to provide planned, brief therapeutic interventions to persons within the priority populations and eligible recipients in the Medicaid program who require time-limited medically necessary services.			
46	(2) A person receiving more than fifteen hours of service in a twelve-month period shall receive a full intake evaluation as described in Section 410(2) of this Chapter.			
47	(3) The provider of brief intervention services shall gather the following information in the intake to brief interventions: (a) Mental status examination; (b) Functioning in daily life domains, showing strengths as well as needs; (c) Substance use and abuse; (d) The name of the consumer's most recent physician and prescribed medications, if known; (e) A brief plan of action to achieve mutually agreed upon outcomes; and (f) The intake evaluation shall not present a barrier to service. When seeking information from the consumer might pose a barrier to service, any of the above items may be left incomplete, providing that non-completion and reasons are documented in the record.			
48	(4) Licensed providers not contracting with an RSN or PHP are exempt from the requirements of subsection (1) of this section.			

COMMENTS AND RECOMMENDATIONS: _____

WAC 275-57-410 - COMMUNITY SUPPORT SERVICES - GENERAL REQUIREMENTS

LICENSE STANDARD #	WAC SECTION/WAC PROVISION	SOURCE OF DOCUMENT	DOCUMENTATION SUITABLE	IMPLEMENTATION
	The RSN, <u>or its designee</u> , shall provide community support services to persons requiring ongoing supports to live in the community. Each community support service, as defined in sections 420 through 450 of this chapter, shall meet the requirements of this section.			
49	(1) Admissions Resource management services shall approve consumer admission to community support services.			
50	(2) Intake Evaluation The provider and consumer, or legally responsible other, shall collaboratively identify consumer strengths and needs through a full intake evaluation completed within thirty days of initiating community support services. Staff conducting an intake evaluation shall have training in this activity (a) The provider shall address in an intake evaluation			
51	(I) Psycho-social and cultural history			
52	(II) Functioning in daily life domains, showing strengths as well as needs			
53	(III) Substance use and abuse			

54	(iv)	Medical history, including medications used. For persons receiving care from a health care professional, the provider shall seek permission to receive pertinent medical information. For persons not under the care of a health care professional, the provider shall offer to make a referral for a physical examination; and			
55	(v)	For children, a developmental history			
56	(b)	The provider shall, when possible, include input from family members and/or other natural support systems, when acceptable to the person.			
57	(c)	The provider may reference or include historical information from other providers as part of the intake evaluation.			
58	(d)	When seeking information from the consumer might pose a barrier to service, the provider may leave incomplete requirements of subsection (2) of this section; providing that the provider documents noncompletion and reasons in the record			
59	(3)	Individualized Plan. The provider shall implement an individualized plan in collaboration with the consumer within thirty days of initiating community support services. The provider shall:			

WAC SECTION 275-57-410 - COMMUNITY SUPPORT SERVICES - GENERAL REQUIREMENTS (CONTINUED)

LICENSE STANDARD #	WAC SECTION/WAC PROVISION	SOURCE OF DOCUMENT	DOCUMENTATION SUITABLE	IMPLEMENTATION
60	(a) For adults, develop the plan with the consumer and include people who provide active support to the consumers (e.g., family members, teachers, etc.), at the consumer request;			
61	(b) For children, develop the plan with the child, family and others who provide active support to the child. For children under three, the plan shall be integrated with the individualized family service plan (IFSP), when applicable;			
62	(c) Focus on normalization and address needs identified by the consumer, which may include: (i) Least restrictive housing; (ii) Income; (iii) Work or school; (iv) Social life; (v) Treatment including psychotherapy; and (vi) Services to address the specialized needs of underserved populations.			
63	(d) Link outcomes to specific goals and time frames for achieving the outcomes;			
64	(e) Define services to achieve the identified outcomes. The provider shall flexibly develop or purchase services to meet the unique needs of the person.			
65	(f) Be responsive to the consumer's age, culture, and disability; and			
66	(g) Assure the plan is mutually reviewed every six months, or more often at the request of the consumer.			

67	(4) Documentation (a) The provider shall periodically document consumer progress in achieving treatment goals in the case record.			
68	(b) The provider shall include in the case record specific progress toward established goals, changes in individualized plans, and extraordinary events.			
69	(c) A mental health professional shall review and sign off on the intake evaluation, the individualized plan, and revisions to the individualized plan.			

COMMENTS AND RECOMMENDATIONS: _____

WAC 275-57-420 COMMUNITY SUPPORT SERVICES - CASE MANAGEMENT SERVICES

LICENSE STANDARD #	WAC SECTION/WAC PROVISION	SOURCE OF DOCUMENT	DOCUMENTATION SUITABLE	IMPLEMENTATION
	<p>The RSN, or its designee, shall provide case management services including outreach and support to achieve the individualized plan's outcomes. Case management services shall;</p> <p>(1) Maximize the consumer's desired level of independence and appropriate interdependence. To this end, case management staff shall help the consumer:</p>			
70	<p>(a) Access basic needs in an age and culturally competent manner, including:</p> <p>(i) Housing;</p> <p>(ii) Food;</p> <p>(iii) Income;</p> <p>(iv) Health and dental care; and</p> <p>(v) Transportation</p>			
71	<p>(b) Work or participate in other daily activities appropriate to the consumer's age and culture;</p>			
72	<p>(c) Link with the regular social life of the community;</p>			
73	<p>(d) Access other needed services, such as substance abuse treatment, and health care;</p>			
74	<p>(e) Resolve crises in least-restrictive settings; and</p>			
75	<p>(f) Manage symptoms by providing information and education about consumer's illness and treatment;</p>			
76	<p>(2) Assist family members and other care givers in their efforts to support and care for the consumer;</p>			

77	(3) Include, as necessary, flexible application of funds, such as rent subsidies, rental deposits, and in-home care to enable stable community living; and			
78	(4) Provide services where and when needed.			

COMMENTS AND RECOMMENDATIONS:

WAC 275-57-430 - COMMUNITY SUPPORT SERVICES - RESIDENTIAL SERVICES

LICENSE STANDARD #	WAC SECTION/WAC PROVISION	SOURCE OF DOCUMENT	DOCUMENTATION SUITABLE	IMPLEMENTATION
79	The RSN, <u>or its designee</u> , shall provide residential services emphasizing least-restrictive, stable living situations appropriate to the age, culture, and residential needs of each consumer.			
80	(2) Where the RSN provides supervised residential services in an adult family home, the adult family home shall comply with Chapter 388-76 WAC.			
81	(3) Where the RSN provides supervised residential services in with Chapter 388-73 WAC.			
82	(4) Where the RSN provides residential services in a boarding home facility, the boarding home facility shall comply with Chapter 246-13 WAC.			
83	(5) Where the RSN provides residential services in an adult residential rehabilitative center facility, the adult residential rehabilitative facility shall comply with Chapter 246-325 WAC.			

COMMENTS AND RECOMMENDATIONS: _____

WAC 275-57-440 - COMMUNITY SUPPORT SERVICES - EMPLOYMENT SERVICES

LICENSE STANDARD #	WAC SECTION/WAC PROVISION	SOURCE OF DOCUMENT	DOCUMENTATION SUITABLE	IMPLEMENTATION
84	The RSN, or its designee, shall provide age and culturally appropriate employment services as treatment option to consumers wanting to work. (1) Employment services shall include:			
85	(a) A vocational assessment of work history, skills, training, education, and personal career goals;			
86	(b) Public assistance information;			
87	(c) Active involvement with consumers served in establishing individualized job and career development plans and revisions of the individualized plan accordingly;			
88	(d) Assistance in locating employment opportunities consistent with consumer skills, goals, and interests;			
89	(e) Integrated supported employment, including outreach and support services in the place of employment, if required, as well as the use of other interventions such as job coaching; and			
90	(f) Interaction with the consumers' employer to maintain stability of employment and advise on reasonable accommodation in accordance with the Americans with Disabilities Act (ADA) of 1990. (2) Any RSN, or RSN subcontractor, employing consumers as part of the pre-vocational or vocational program shall:			
91	(a) Pay consumers in accordance with the Fair Labor Standards Act; and			

92	(b) Ensure safety standards are in place in full compliance with local and state regulations			
93	(3) The RSN shall coordinate efforts with rehabilitation and employment services, such as the Division of Vocational Rehabilitation, the state employment services and the business community and job placement services within the community			
94	(4) Agencies accredited by commission on accreditation of rehabilitation facilities (CARF), or rehabilitation services accreditation system (RSAS) shall be considered the same as licensed by the state for employment services. Other organizations with equivalent standards may be considered for state licensure for employment services.			

COMMENTS AND RECOMMENDATIONS: _____

WAC 275-57-450 - COMMUNITY SUPPORT SERVICES - PSYCHIATRIC AND MEDICAL SERVICES

LICENSE STANDARD #	WAC SECTION/WAC PROVISION	SOURCE OF DOCUMENT	DOCUMENTATION SUITABLE	IMPLEMENTATION
95	The RSN, or its designee, shall provide psychiatric and medical services to ensure consumers are prescribed medications, when necessary, to treat symptoms, become knowledgeable about any prescribed medications and side effects, are referred to treatment for non-psychiatric medical problems.			
96	<p>(1) The provider shall vest overall medical responsibility in a physician licensed to practice under Chapter 18.57 or 18.71 RCW, and board eligible in psychiatry. Providers unable to recruit a psychiatrist may employ a physician without board eligibility in psychiatry provided:</p> <p>(a) Psychiatric consultation is provided to the physician at least monthly; and</p> <p>(b) A psychiatrist is accessible in person, by telephone, or by radio communication to the physician for emergency consultation.</p>			
97	(2) Only staff licensed to do so may prescribe medications. Prescribing staff shall review medications at least every three months.			
98	(3) Only staff licensed to do so may administer medications			
	(4) When a consumer receives only medication services from a provider, the provider may develop and implement a brief intake and plan, as defined in section 400 of this chapter in place of the intake evaluation, as defined in section 410 of this chapter			

99	<p>(5) The provider shall maintain medication information in the consumer record documenting at least the following for each prescribed medication:</p> <ul style="list-style-type: none"> (a) Name and purpose of medication; (b) Dosage and method of administration; (c) Dates prescribed, reviewed, and/or renewed; (d) Observed and reported effects, interactions, and side effects. Staff shall query consumers concerning such information; (e) Any laboratory findings; (f) Reasons for change or termination of medication; and (g) Name and signature of prescribing person 			
100	<p>(6) When physical health problems are suspected or identified, the provider shall consult with and/or offer to make a referral to a physician or alternative health care provider. The provider shall include current medical concerns, as necessary, in the individualized plan</p>			

WAC 275-57-450 - PSYCHIATRIC AND MEDICAL SERVICES (CONTINUED)

LICENSE STANDARD #	WAC SECTION/WAC PROVISION	SOURCE OF DOCUMENT	DOCUMENTATION SUITABLE	IMPLEMENTATION
101	(7) Provider staff shall inspect and inventory medication storage areas at least quarterly;			
102	(a) Medications shall be kept in locked, well-illuminated storage;			
103	(b) Medications kept in a refrigerator containing other items shall be kept in a separate container with proper security;			
104	(c) No outdated medications shall be retained, and medications shall be disposed of in accordance with regulations of the State Board of Pharmacy;			
105	(d) Medications for external use shall be stored separately from oral and injectable medications;			
106	(e) Poisonous external chemicals and caustic materials shall be stored separately.			

COMMENTS AND RECOMMENDATIONS: _____

LICENSING AND CERTIFICATION
PERSONNEL RECORD REVIEW TOOL
(HOSPITAL ONLY)

PROVIDER

REVIEWER

DATE

LCS REVIEWER

DATE

PERSONNEL RECORD REVIEW TOOL
WAC CHAPTERS: 275-57, 275-55, and 275-54

INSTRUCTIONS

This tool is intended for use by mental health agency administrators during the self evaluation process, and by Mental Health Division Licensing and QA/IT Section program administrators during the site review of a service provider.

Column (2) - Please list your direct care staff names (support staff not necessary) in the second column

Column (3) - Please indicate any degree attained by individual

Column (4) - Please indicate whether the individual has obtained the necessary experience where applicable

Column (5) - Please indicate whether or not the individual meets MHP requirements under WAC

Column (6) - Please indicate if individual meets requirements for being a child mental health specialist

Column (7) - Please indicate if the individual has an in-service training plan and receives the required training

NOT IMPLEMENTING VOLUNTARY RETIREMENT
 71.05 RCW 71.05.010, WAC CHAPTERS 275-54 AND 275-55

	(2) STAFF MEMBER'S NAME	(3) DEGREE (B.S., M.D., RN, MASTER, ETC.)	(4) REQUIRED BY CHAPTER WAC 275-55-020 (13) and 275-54-020 (14)		(5) TYPE OF MEMBER WAC 275-54-020 (11)		(6) OFFERED BY EMPLOYER		(7) NO YES/NO BY EMPLOYEE	
			YES	NO	YES	NO	YES	NO	YES	NO
1										
2										
3										
4										
5										
6										
7										
8										
9										
10										
11										
12										

STAFF IMPLEMENTING INVOLUNTARY TREATMENT OF
71.05 RCW, 71.34 RCW, WAC CHAPTERS 275-54 AND 275-56

	(2) STAFF MEMBER NAME	(3) DEGREE BS, MS, RN, MASTER, ETC.	(4) REQUIRED EXPERIENCE WAC 275-55-020 (13) and 275-56-020 (14)		(5) MHP QUALIFIED WAC 275-55-020 (13) and 275-56-020 (14)		(6) CHILD ABUSE TRAINING WAC 262-55-0700		(7) WAC 275-54-020 (13) and 275-55-020 (14)	
			YES	NO	YES	NO	YES	NO	YES	NO
1										
2										
3										
4										
5										
6										
7										
8										
9										
10										
11										
12										

INSTRUCTIONS

The Provider Agency Self Evaluation and State Certification Survey Tool is a dual purpose document designed to be employed by all certified mental health provider agencies in an internal self evaluation of compliance with statewide standards as expressed in WAC 275-54 and 275-55. It will also be used by the Licensing and Certification Section of the Mental Health Division in determining the extent to which provider agencies meet certification requirements.

SURVEY TOOL FORMAT EXPLANATION:

CERTIFICATION STANDARD #	WAC PROVISION WAC REFERENCE	SOURCE OF DOCUMENTATION (AGENCY REF)	DOCUMENTATION FINDING	OPERATIONAL IMPLEMENTATION FINDING
-----------------------------	--------------------------------	--	--------------------------	--

The provider agency shall identify the source of documentation for each certification standard (WAC Provision) e.g., personnel file, consumer record and page of policy manual, etc. When doing the survey the reviewer shall enter either a C-for full compliance, a D-for Deficiency or an M-for missing documentation in both the documentation column and the implementation column thereby indicating the quality of the documentation and also the quality of the implementation of standards. This internal self evaluation should be done annually and result in corrective actions to be performed as required. Copies of the most recent self evaluation and records of corrective actions required and completed must be retained in agency files. Upon completion of the self-evaluation survey, agency Directors shall review, approve and sign the document prior to furnishing a copy of it and any resultant corrective actions to the Chair of the agency board of directors who, in turn, are to review, approve and sign the document.

When the Licensing & Certification Section of the State Mental Health Division performs its certification review, it will use the most recent completed provider agency self evaluation document in the same manner as described for the provider above.

Buia

PROVIDER AGENCY

SELF EVALUATION AND CERTIFICATION ADMINISTRATIVE SURVEY TOOL

WAC 275-54 AND/OR 275-55

Provider: _____

RSN/County: _____

Provider Reviewer: _____ Date: _____

Certification Reviewer: _____ Date: _____

Review Materials Needed:

- * The detailed plan for the operation of agency services - Policy and Procedure Manual
- * RSN/Agency contract and agency agreements
- * Management information report requirements
- * Quality Assurance program description and records
- * Personnel records (including medical staff)
- * List of mental health professional, specialists and consultants (with signatures)
- * Training records and plans
- * Clinical supervision records
- * Staff evaluation records
- * Copy of voluntary and involuntary consumer rights statements for children and adults

- Grievance records
- Agency program service descriptions for certified services

I CERTIFY THAT I HAVE REVIEWED AND APPROVE THIS AGENCY'S SELF-EVALUATION

Signature: _____ Date: _____
Agency Director

Signature: _____ Date: _____
Agency Board Chair

**WAC 275-54 AND/OR 275-55
GENERAL REQUIREMENTS**

CERTIFICATION STANDARD #	WAC PROVISION - WAC REFERENCE	SOURCE OF DOCUMENT	DOCUMENTATION SUITABLE	IMPLEMENTATION
1	The provider has a contract or written agreement with the RSN to provide the services for which it is applying for certification. WAC 275-54-160 (1), 275-55-261 (1)			
2	The provider is a recognized element of the RSN'S mental health plan. WAC 275-54-160 (3), 275-55-261 (5)			
3	The RSN plan designates the components to be provided by the provider seeking certification. WAC 275-54-160 (5), 275-55-261 (5)			
4	The provider provides at least one of the following components: Outpatient; Emergency; Inpatient. WAC 275-54-170 (1)(a), 275-55-263 (1)(a)			

COMMENTS AND RECOMMENDATIONS:

**WAC 275-54 AND/OR 275-55
GENERAL REQUIREMENTS**

CERTIFICATION STANDARD #	WAC SECTION/WAC PROVISION	SOURCE OF DOCUMENT	DOCUMENTATION SUITABLE	IMPLEMENTATION
5	<p>The provider maintains a written statement describing the organizational structure and objectives.</p> <p>This written statement includes contractual affiliates (if any). WAC 275-54-170 (1)(c), 275-55-263 (1)(c)</p>			
6	<p>Client rights are included in the statement of structure and objectives. WAC 275-54-170 (1)(d)(ii), 275-55-263 (1)(d)(ii)</p>			
7	<p>FOR CHILDREN: Client rights are prominently posted and include, at a minimum, the rights listed in WAC 275-54-290</p> <p>FOR ADULTS: Client rights are prominently posted and include, at a minimum, the rights listed in WAC 275-55-211 and 275-55-241</p>			
8	<p>The provider safeguards clinical records against loss, defacement, tampering or use by unauthorized persons. WAC 275-54-170 (2)(b)(ii), 275-55-263 (2)(a)(ii)</p>			

COMMENTS AND RECOMMENDATIONS: _____

CERTIFICATION STANDARD #	WAC SECTION/WAC PROVISION	SOURCE OF DOCUMENT	DOCUMENTATION SUITABLE	IMPLEMENTATION
9	<p>Evaluation and treatment services to minors shall be provided by:</p> <p>A child mental health specialist, (WAC 275-54-170 (2)(c)(i)) or</p> <p>A mental health professional directly supervised by a child mental health specialist, (WAC 275-54-170 (2)(c)(ii)) or</p> <p>A mental health professional receiving at least one hour per week or clinical consultation from a child mental health specialist for each involuntarily detained minor provided direct client services during the week (WAC 275-54-170 (2)(c)(iii))</p>			
10	<p>Professional personnel are available to the provider WAC 275-54-170 (2)(d)(ii), WAC 275-55-263 (2)(b)(i)</p> <p>A licensed physician is available, and</p> <p>A mental health professional is available</p>			
11	<p>Psychiatric consultation is available to other physicians or mental health professionals when treatment is not provided by or under the supervision of a psychiatrist. WAC 275-54-170 (2)(d)(iv), WAC 275-55-263 (2)(b)(iii)</p>			
12	<p>The provider provides access to medical services. WAC 275-54-170 (2)(d)(iii), 275-55-263 (2)(b)(ii)</p>			
13	<p>The provider provides access to emergency life sustaining treatment WAC 275-54-170(2)(d)(iii), WAC 275-55-263(2)(b)(ii)</p>			
14	<p>The provider provides access to medication. WAC 275-54-170 (2)(d)(iii), WAC 275-55-263 (2)(b)(ii)</p>			

COMMENTS AND RECOMMENDATIONS:

CERTIFICATION STANDARD #	WAC SECTION/WAC PROVISION	SOURCE OF DOCUMENT	DOCUMENTATION SUITABLE	IMPLEMENTATION
15	The provider has a written policy for the use of restraints or seclusion which ensures the safety of patients and staff. WAC 275-54-170 (2)(e), WAC 275-55-263 (2)(c)			
16	<p>The provider has an in-service training plan containing the following elements:</p> <ul style="list-style-type: none"> a) Utilization of less restrictive alternatives; b) Methods of patient care; c) Managing assaultive and/or self-destructive behavior; d) Standards and guidelines promulgated by the department. (WAC 275-54-170 (2)(g), WAC 275-55-263 (2)(e)) 			

COMMENTS AND RECOMMENDATIONS:

CERTIFICATION STANDARD #	WAC SECTION/WAC PROVISION	SOURCE OF DOCUMENT	DOCUMENTATION SUITABLE	IMPLEMENTATION
17	The provider maintains written procedures for managing assaultive and/or self-destructive behavior. WAC 275-54-170(2)(h)(i), WAC 275-55-263(2)(f)(i) Staff are familiar with these procedures.			
18	The provider maintains adequate fiscal accounting records. WAC 275-54-170(2)(h)(ii), WAC 275-55-262(2)(f)(ii)			
19	The provider submits reports required by the secretary. WAC 275-54-170 (2)(h)(iii), WAC 275-55-263 (2)(f)(iii)			
20	The provider maintains a procedure for collection of fees and third-party payment. WAC 275-54-170 (2)(h)(iv), WAC 275-55-263 (2)(f)(iv)			
21	The provider is subject to licensure under other federal or state statute. The provider is regulated by _____ The provider meets the standards of the other regulator. (The more restrictive standards shall apply). WAC 275-54-170 (?), WAC 275-55-263 (3)			

COMMENTS AND RECOMMENDATIONS: _____

**WAC 275-54 AND/OR 275-55
OUTPATIENT SERVICES**

CERTIFICATION STANDARD #	WAC SECTION/WAC PROVISION	SOURCE OF DOCUMENT	DOCUMENTATION SUITABLE	IMPLEMENTATION
22	Services are provided directly by: a) A licensed physician; or b) A licensed psychologist; or c) A licensed psychiatric nurse; or d) A licensed agency. WAC 275-54-180 (1), WAC 275-55-271(1)			
23	The provider provides: a) Individual and/or group therapy; and/or b) Family/marital therapy, and/or c) Medication management, and/or d) Case Management WAC 275-54-180 (2)(a)(i through v) WAC 275-55-271(2)(a)			
24	Services are provided under the supervision of a mental health professional. WAC 275-54-180 (2)(b), WAC 275-55-271(2)(b)			
25	The provider has access to consultation by a psychiatrist or a physician with at least one year's experience in the direct treatment of the mentally ill. WAC 275-54-180 (2)(d), WAC 275-55-271(2)(d)			

COMMENTS AND RECOMMENDATIONS: _____

Bria

**WAC 275-54 AND/OR 275-55
EMERGENCY SERVICES**

CERTIFICATION STANDARD #	WAC SECTION/WAC PROVISION	SOURCE OF DOCUMENT	DOCUMENTATION SUITABLE	IMPLEMENTATION
26	The provider has the capacity to detain a person posing an imminent threat to self or others. WAC 275-54-190 (1), WAC 275-55-281(1)			
27	The provider is available seven days per week, twenty four hours per day. WAC 275-54-190 (3)(a), WAC 275-55-281(3)(a)			
28	The provider follows a written protocol for detaining an individual and contacting the designated mental health professional. WAC 275-54-190 (3)(b), WAC 275-55-271(3)(b)			
29	The provider provides or has access to medical services. WAC 275-54-190 (3)(c), WAC 275-55-281(3)(c)			
30	The provider has a written agreement with a certified inpatient component for admissions on a seven day per week, twenty four hour per day basis. WAC 275-54-190 (3)(d), WAC 275-55-281(3)(d)			
31	The provider follows a written protocol for transporting individuals to short term inpatient units. WAC 275-54-190 (3)(e), WAC 275-55-281(3)(e)			

COMMENTS AND RECOMMENDATIONS: _____

**WAC 275-54 AND/OR 275-55
SHORT-TERM INPATIENT SERVICES**

LICENSE STANDARD #	WAC SECTION/WAC PROVISION	SOURCE OF DOCUMENT	DOCUMENTATION SUITABLE	IMPLEMENTATION
32	Services are provided on a twenty four hour per day basis. WAC 275-54-200 (1), 275-55-291 (1)			
33	<p>The provider meets requirements for state licensing as</p> <ul style="list-style-type: none"> a) A skilled nursing facility; or b) An intermediate care facility; or c) A residential treatment facility. <p>WAC 275-54-200 (3)(a), 275-55-291 (3)(a)</p>			
34	The provider has access to or provides at least one seclusion room, meeting the requirements of WAC 243-16-001 (65) WAC 275-54-200 (3)(e), 275-55-291(3)(e)			
35	<p>The provider provides therapeutic services including</p> <ul style="list-style-type: none"> a) Individual therapy; b) Family therapy (for children) c) Medication Management <p>WAC 275-54-200 (3)(f), 275-55-291(3)(f)</p>			
36	The provider has a professional person in charge to supervise the provision of treatment. WAC 275-54-200 (3)(g), 275-55-291(3)(g)			
37	The provider has access to a mental health professional and a licensed physician for consultation and communication with the individual and staff, twenty-four hours per day, seven days per week. WAC 275-54-200 (3)(i), 275-55-291(3)(i)			

COMMENTS AND RECOMMENDATIONS: _____

CONSUMER RECORD REVIEW

WAC 275-54 and/or WAC 275-55

PROVIDER _____
CASE # _____
LCS REVIEWER _____
DATE _____

SERVICES PROVIDED

1. CHECK TYPE IF INVOLUNTARY TREATMENT SERVICES WERE PROVIDED

- ☐ EMERGENCY DETENTION (UP TO 6 HRS) ☐ 72 - HOUR DETENTION
☐ 14 - DAY COMMITMENT ☐ 90 - DAY COMMITMENT ☐ 180 - DAY COMMITMENT

2. CHECK TYPE IF OUTPATIENT SERVICES WERE RECEIVED BY THE CONSUMER

- ☐ INDIVIDUAL/GROUP THERAPY
☐ FAMILY/MARITAL THERAPY
☐ MEDICATION MANAGEMENT
☐ CASE MANAGEMENT

3. CHECK IF EMERGENCY SERVICES WERE PROVIDED

- ☐ EMERGENCY SERVICES

4. CHECK TYPE IF SHORT-TERM INPATIENT WERE RECEIVED BY CONSUMER

- ☐ INDIVIDUAL/FAMILY THERAPY
☐ MEDICATION MANAGEMENT

AGE _____ IF CHILD A SPECIALIST INVOLVEMENT IS REQUIRED

DATE OF INITIAL CONTACT _____
DATE OF LAST COURT ORDER _____
DATE OF TERMINATION _____

list the staff involved in the direct treatment of the client. Identify those who qualify as Mental Health Professionals.

Non - MHP's _____
MHP's _____

Component	Deficiency Standard # (circle numbers if deficient)	Total Points Possible	# of NA's	Net Possible	# of Deficiencies	Net Score
General E&T	1 2 3 4 5 6 7 8 9 10 11 12	26				
Outpatient	13 14 15 16 17	9				
Emergency	18 19 20 21 22	6				
Short Term Inpatient	23 24 25 26 27 29	14				
Total		55				

PERCENTAGE SCORE _____

Bo

CLIENT RECORD REVIEW WAC 275-54 AND/OR 275-55

THIS SECTION OF THE REVIEW IS TO MEASURE AND EVALUATE THE DOCUMENTATION RECORDED IN THE CLIENT'S CASE RECORD. THIS SECTION IS TO BE COMPLETED BY ALL PROVIDERS. UNDER THE SOURCE, PLEASE INDICATE THE CLIENT RECORD FORM AND THE DATE OF ENTRY WHICH DOCUMENTS THE FOLLOWING ITEMS:

CERTIFICATION STANDARD #	WAC PROVISION - WAC REFERENCE	SOURCE OF DOCUMENT	DOCUMENTATION SUITABLE	IMPLEMENTATION		
1	The client was provided care in a therapeutic environment. WAC 275-54-170 (1)(d) (i), 275-55-263 (1)(d)(i)			Yes	No	NA
2	The client was informed of his/her rights as specified in WAC 275-54-190 (Children) or WAC 275-55-241 (adults) WAC 275-54-170 (1) (d) (ii), 275-55-263 (1)(d)(ii)			Yes	No	NA
3	A less restrictive alternative was considered for this client at the time of: detention. admission. discharge. development of 14, 90 - day (for adults) and 180 day petitions. WAC 275-54-170 (1) (d) (iii), 275-55-263 (1)(d)(iii)			Yes	No	NA
				Yes	No	NA
				Yes	No	NA
				Yes	No	NA
				Yes	No	NA
4	If consumer requires services that are not available and/or provided at this facility then the agency shall document in the record and otherwise ensure that <u>referral services and assistance in obtaining supportive services</u> are provided. WAC 275-54-170 (1)(d)(v), 275-55-263 (1)(d)(v)			Yes	No	NA

COMMENTS AND RECOMMENDATIONS: _____

CLIENT RECORD REVIEW **WAC 275-54 AND/OR 275-55**

CERTIFICATION STANDARD #	WAC SECTION/WAC PROVISION	SOURCE OF DOCUMENT	DOCUMENTATION SUITABLE	IMPLEMENTATION												
5	<p>The clinical record includes:</p> <ul style="list-style-type: none">a treatment plana discharge plan.sufficient information to justify the diagnosis.Sufficient information to justify the treatment program. <p>WAC 275-54-170 (2)(b)(i)(ii), 275-55-263 (2)(a)(i)(ii)</p>			<p>Meets all of the requirements</p> <table><tr><td>Yes</td><td>No</td><td>NA</td></tr><tr><td>Yes</td><td>No</td><td>NA</td></tr><tr><td>Yes</td><td>No</td><td>NA</td></tr><tr><td>Yes</td><td>No</td><td>NA</td></tr></table>	Yes	No	NA	Yes	No	NA	Yes	No	NA	Yes	No	NA
Yes	No	NA														
Yes	No	NA														
Yes	No	NA														
Yes	No	NA														
6	<p>FOR CHILDREN:</p> <p>Evaluation and treatment services were provided by:</p> <ul style="list-style-type: none">A child mental health specialist orA mental health professional directly supervised by a child mental health specialist, orA mental health professional receiving at least one hour per week of clinical consultation from a child mental health specialist for each involuntarily detained minor provided direct client services during a week. <p>WAC 275-54-170 (2) (c) (ii) (iii),</p>			<p>Meets at least one (1) of the requirements</p> <table><tr><td>Yes</td><td>No</td><td>NA</td></tr></table>	Yes	No	NA									
Yes	No	NA														

COMMENTS AND RECOMMENDATIONS: _____

**CLIENT RECORD REVIEW
WAC 275-54 AND/OR 275-55**

CERTIFICATION STANDARD #	WAC SECTION/WAC PROVISION	SOURCE OF DOCUMENT	DOCUMENTATION SUITABLE	IMPLEMENTATION		
7	Patient had access to necessary: <ul style="list-style-type: none"> • medical treatment • emergency life sustaining treatment • medication WAC 275-54-170 (2) (d) (iii), WAC 275-55-263 (2) (b) (ii),			Meets all of the requirements		
				Yes	No	NA
				Yes	No	NA
				Yes	No	NA
8	Psychiatric consultation is available to physician(s) and other mental health professionals when treatment is not provided under the supervision of a psychiatrist. <i>If a psychiatrist is providing treatment mark NA</i> WAC 275-54-170 (2) (d) (iv), WAC 275-55-263 (2) (b) (iii),			Yes	No	NA
9	For the emergency use of restraints, a physician was notified within one hour. WAC 275-54-170 (2) (e) (i), WAC 275-55-263 (2) (c) (i)			Yes	No	NA
10	If the client was restrained or secluded for more than two hours, they were evaluated by a mental health professional. While restrained or secluded, the patient was directly observed every 15 minutes. WAC 275-54-170 (2) (e) (ii), WAC 275-55-263 (2) (c) (ii)			Yes	No	NA
				Yes	No	NA

**CLIENT RECORD REVIEW
WAC 275-54 AND/OR 275-55**

CERTIFICATION STANDARD #	WAC SECTION/WAC PROVISION	SOURCE OF DOCUMENT	DOCUMENTATION SUITABLE	IMPLEMENTATION		
11	If the restraint or seclusion exceeded twenty-four hours, the patient was examined by a licensed physician?			Yes	No	NA
	The facts determined by the physician were recorded in the client's record to justify the use of restraints or seclusion in excess of twenty-four hours.			Yes	No	NA
	The physician signed the order for the use of restraints or seclusion.			Yes	No	NA
	The procedure was repeated for each subsequent twenty-four hour period?			Yes	No	NA
	WAC 275-54-170 (2) (e) (iii), WAC 275-55-263 (2) (c) (iii)					
12	There is documentation in the chart that ensures that the patient had been evaluated for release from commitment:			Yes	No	NA
	<u>Weekly</u> - for 14 day commitment <u>Monthly</u> - for 90 and 180 - day commitments WAC 275-54-170 (2) (f), WAC 275-55-263 (2) (d)			Yes	No	NA

COMMENTS AND RECOMMENDATIONS: _____

**CLIENT RECORD REVIEW
WAC 275-54 AND/OR 275-55
OUTPATIENT SERVICES**

CERTIFICATION STANDARD#	WAC SECTION/WAC PROVISION	SOURCE OF DOCUMENT	DOCUMENTATION SUITABLE	IMPLEMENTATION
13	Services are provided directly by one of the following: A licensed physician. A licensed psychologist. A licensed psychiatric nurse A licensed agency. WAC 275-54-180(1), WAC 275-55-271(1)			Meets at least one of the requirements Yes No NA
14	Services provided to the client include at least one of the following: Individual therapy. Group therapy. Family/marital therapy. Medication management. Case management. WAC 275-54-180 (2) (a), WAC 275-55-271 (2) (a)			Services provided include at least one (1) from the list Yes No NA
15	Was the involuntary client seen at least weekly? WAC 275-54-180 (2) (c), 275-55-271 (2) (a)			Yes No NA

 COMMENTS AND RECOMMENDATIONS:

**CLIENT RECORD REVIEW
WAC 275-54 AND/OR 275-55
OUTPATIENT SERVICES**

CERTIFICATION STANDARD #	WAC SECTION/WAC PROVISION	SOURCE OF DOCUMENT	DOCUMENTATION SUITABLE	IMPLEMENTATION		
16	<p>The patient is seen weekly by assigned staff during involuntary treatment.</p> <p>If the frequency of contact was not at least weekly, the mental health professional shall record the reason in the client's record.</p> <p>A mental health professional has reviewed and updated the treatment plan at least monthly.</p> <p>If the reviews and updates are not monthly then the mental professional must document in the reason for this in the client record.</p> <p>WAC 275-54-180 (2) (c), WAC 275-55-271 (2) (c)</p>			Yes	No	NA
				Yes	No	NA
				Yes	No	NA
				Yes	No	NA
17	<p>If under a 14 day commitment, the client has at least weekly consultation for the assessment and prescription of psychotropic medication? If not, a physician must record the reason in the client record.</p> <p>If under a 90 day or 180 day commitment, the client has at least monthly consultation for the assessment and prescription of psychotropic medication? If not, a physician must record the reason in the client record.</p> <p>WAC 275-54-180 (2) (e), WAC 275-55-271 (2) (e)</p>			Yes	No	NA
				Yes	No	NA

COMMENT AND RECOMMENDATIONS: _____

**CLIENT RECORD REVIEW
WAC 275-54 AND/OR 275-55
EMERGENCY SERVICES**

CERTIFICATION STANDARD #	WAC SECTION/WAC PROVISION	SOURCE OF DOCUMENT	DOCUMENTATION SUITABLE	IMPLEMENTATION		
18	The provider's written protocol for detaining an individual was followed: WAC 275-54-190 (2) (b), WAC 275-55-281 (2) (b)			Yes	No	NA
19	The client was evaluated by a county designated mental health professional within six hours of detention. RCW 71.05.050 and WAC 275-55-281 (2) (b)			Yes	No	NA
20	Did the provider provide or have access to medical services? WAC 275-54-190 (2) (c), WAC 275-55-281 (2) (c)			Yes	No	NA
21	Did the provider transfer the client to a certified inpatient component for admissions? If so, did the provider have a written agreement with the inpatient component? WAC 275-54-190 (2) (d), WAC 275-55-281 (2) (d)			Yes Yes	No No	NA NA
22	Did the provider follow its written protocol for transporting individuals to short-term inpatient units? WAC 275-54-190 (2) (e), WAC 275-55-281 (2) (e)			Yes	No	NA

COMMENTS AND RECOMMENDATIONS: _____

**CLIENT RECORD REVIEW
WAC 275-54 AND/OR 275-55
SHORT-TERM INPATIENT SERVICES**

LICENSE STANDARD #	WAC SECTION/WAC PROVISION	SOURCE OF DOCUMENT	DOCUMENTATION SUITABLE	IMPLEMENTATION		
23	FOR CHILDREN: Minor detained with adults. The record documented: WAC 275-54-170 (2) (a)			Yes	No	NA
	The anticipated effects of such joint use on the minor been considered by the professional staff. WAC 275-54-170 (2) (a) (i)			Yes	No	NA
	A professional judgment had been made that joint use would not be deleterious to the minor. WAC 275-54-170 (2) (a) (ii)			Yes	No	NA
	No other placement within a certified inpatient facility was available. WAC 275-54-170 (2) (a) (ii)			Yes	No	NA
24	Did the provider deny admission to this client? WAC 275-54-200 (3) (c) WAC 275-55-291 (3) (c)			Yes	No	NA
				Yes	No	NA

COMMENTS AND RECOMMENDATIONS: _____

**CLIENT RECORD REVIEW
WAC 275-54 AND/OR 275-55
SHORT-TERM INPATIENT**

CERTIFICATION STANDARD #	WAC SECTION/WAC PROVISION	SOURCE OF DOCUMENT	DOCUMENTATION SUITABLE	IMPLEMENTATION		
25	<p>If admission was denied, does the record indicate:</p> <p>After a psychosocial evaluation, there was a determination by a mental health professional that the person did not present a likelihood of serious harm, or an imminent likelihood of serious harm or was not gravely disabled?</p> <p>The person required specialized medical care and support services of a type not provided by the provider?</p> <p>The person required a greater degree of control than the program could provide?</p> <p>No treatment space available?</p> <p>A less restrictive alternative provided by another provider was a more appropriate placement?</p> <p>WAC 275-54-200 (3) (c) (i thru v) WAC 275-55-291 (3) (c) (i thru v)</p>			Yes	No	NA
				Yes	No	NA
				Yes	No	NA
				Yes	No	NA
				Yes	No	NA
				Yes	No	NA
26	<p>A medical evaluation was performed by a licensed physician within twenty-four hours of admission?</p> <p>WAC 275-54-200 (3) (d) (i) WAC 275-55-291 (3) (d) (i)</p>			Yes	No	NA
27	<p>A psychosocial evaluation was performed by a mental health professional within twenty-four hours of admission?</p> <p>WAC 275-54-200 (3) (d) (ii) WAC 275-55-291 (3) (d) (ii)</p>			Yes	No	NA

COMMENTS AND RECOMMENDATIONS: _____

**CLIENT RECORD REVIEW
WAC 275-54 AND/OR 275-55
SHORT-TERM INPATIENT**

CERTIFICATION STANDARD #	WAC SECTION/WAC PROVISION	SOURCE OF DOCUMENT	DOCUMENTATION SUITABLE	IMPLEMENTATION
29	Does the record indicate a mental health professional provided daily contact with the client for the purpose of observation, evaluation, and continuity of treatment? WAC 275-54-200 (3) (h), WAC 275-55-291 (3) (h)			Yes No NA

COMMENTS AND RECOMMENDATIONS: _____

MENTAL HEALTH DIVISION

Consumer Record Review
6547 Exempt (shaded areas)
 Reviewer _____

PROVIDER: _____

CHART NUMBER _____

GENDER: MALE FEMALE AGE _____

DATE OF INTIAL CONTACT/INTAKE _____

DATE OF TERMINATION _____ ONGOING _____

Services Provided:	Underserved Population:	YES NO
Case Management	American Indian/Alaska Native	Asian/Pacific Islander
Psychiatric/Medical	African American	Hispanic
Brief Intervention	Children	Elderly
Residential	Disabled	Low Income
Employment	Developmentally Disabled	Deaf and Hard of Hearing
Crisis Response	Co-occurring Disorder	

Staff involved in direct treatment		MHP	Yes	No	Specialist	Yes	No
1. _____		<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
2. _____		<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
3. _____		<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Areas Reviewed	Deficiency, please circle number In each area.	Total Pts.	# of na's	Net Pts.	# of Def.	Score
Consumer Rights	1, 2, 3, 4, 5, 6, 7	7				
Intake	1, 2, 3, 4, 8, 12	6				
Individualized Plan	1, 2, 3, 4, 5, 6, 13, 14, 15, 16,	10				
Consent to Treatment	1, 2, 3, 4, 5, 6	6				
Special Populations	1, 2, 3, 4	4				
Psychiatric/Medical	1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16	16				
Brief Intervention	1, 2, 3, 4, 5, 6, 7, 8	8				
Employment	1, 2, 3, 4, 5, 6, 7, 8.	8				
Case Management	1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15,	15				
Crisis Response	1, 2, 3, 4, 5, 6, 7, 8	8				
Total Possible		88				

Chart Score = Total Correct (column 7) _____ / Total Possible (column 5) _____ = _____ %
 90% or > is a passing score

BNA

Justification	Standard	Federal Waiver Requirement
----------------------	-----------------	-----------------------------------

CONSUMER RIGHTS

Justification	Standard	Compliance
1. WAC 275-57-340 Consumer Rights	The provider shall ensure consumers are knowledgeable of and protected by certain rights	Patient rights have been signed by consumer or chart indicates they were verbally informed.. <input type="checkbox"/> YES <input type="checkbox"/> NO
2. WAC 275-57-340 (i)	Consumer has a right to lodge a complaint with the Ombuds.	Patient rights include the right of the consumer to lodge a complaint and rights include the phone number of Ombuds. <input type="checkbox"/> YES <input type="checkbox"/> NO
3. WAC 275-57-110(5)	The consumer shall have the right to choose a primary care provider (PCP) from the (PCP) available.	Patient rights include information about the consumers right to choose a PCP. <input type="checkbox"/> YES <input type="checkbox"/> NO
4. WAC 275-57-210 (4)	A person enrolled in a PHP shall have the right to change primary care provider.	The right to change a PHP is included in the patient rights. <input type="checkbox"/> YES <input type="checkbox"/> NO
5. WAC 275-57-200	The department shall not require a person to enroll or continue to enroll in a PHP.	The right to request an exemption from enrollment in is included in the patient rights. <input type="checkbox"/> YES <input type="checkbox"/> NO
6. WAC 275-57-240	An enrolled recipient shall have the right to a second opinion.	The right to a second opinion is included in the patient rights. <input type="checkbox"/> YES <input type="checkbox"/> NO
7. WAC 275-57-250(2)(iii)	The department shall: Disenroll only when the enrolled recipient requests disenrollment from the PHP.	The right to request disenrollment from the PHP is included in the patient rights. <input type="checkbox"/> YES <input type="checkbox"/> NO

Justification	Standard	Compliance
---------------	----------	------------

INTAKE

1. WAC 275-57-410 (1) Admissions	Resource management shall approve consumer admission to community support services.	Tier (level of care) authorization and/or approval for treatment is found in chart. <input type="checkbox"/> YES <input type="checkbox"/> NO
2. WAC 275-57-410 (2) Intake Evaluation. "Medical Audit" Federal Waiver The degree to which services and planning incorporate the service recipient's voice. "Acceptability"	Intake shall be done collaboratively with the consumer.	Records Indicate the consumer has signed or participated in the intake. <input type="checkbox"/> YES <input type="checkbox"/> NO
3. WAC 275-57-410 (2)	Intake shall be done within 30 days of initiating community support services	Records Indicate the intake was completed with 30 days of first contact <input type="checkbox"/> YES <input type="checkbox"/> NO
4. WAC 275-57-410 (2)(a)(ii) "Medical Audit" Federal Waiver The degree to which services provided are driven by recipient needs. "Quality of Care"	Intake addresses functioning of daily life domains, showing strengths as well as needs.	Daily life domains addressed, showing strengths as well as needs. <input type="checkbox"/> YES <input type="checkbox"/> NO
5. WAC 275-57-410 (2)(a)(i)	Intake addresses psycho-social and cultural history	Psycho-social and cultural history was addressed at intake. <input type="checkbox"/> YES <input type="checkbox"/> NO
6. WAC 275-57-410 (2)	Staff conducting an intake shall have training in this activity.	Staff conducting intake is a MHP or signed by MHP. <input type="checkbox"/> YES <input type="checkbox"/> NO
7. WAC 275-57-410 (2)(a)(iii)	Intake addresses substances use and abuse	Substance use and abuse was addressed. <input type="checkbox"/> YES <input type="checkbox"/> NO
8. WAC 275-57-410 (2)(a)(iv)	Intake addresses medical history including medications used.	Medical history including medications was addressed. <input type="checkbox"/> YES <input type="checkbox"/> NO
9. WAC 275-57-410 (2)(b)	Intake addresses historical information from family members and/or other natural support systems when possible.	Historical information about family and other natural support systems addressed. <input type="checkbox"/> YES <input type="checkbox"/> NO
10. WAC 275-57-410 (2)(a)(v)	For Children, a developmental history is required.	Developmental History addressed. <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NA
11. WAC 275-57-410 (2)(a)(iv)	For persons under the care of a health care professional, the provider shall seek permission to receive pertinent medical information.	There is documentation that person was under the care of a health care professional and provider sought to receive pertinent information. <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NA
12. WAC 275-57-410(2)(d)	Seeking information should not pose a barrier to service.	Intake not complete and it is documented why not complete. <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NA

Justification	Standard	Compliance
---------------	----------	------------

INDIVIDUALIZED PLAN

<p>1. WAC 275-57-410 (3) Individualized Plan</p> <p>"Medical Audit" Federal Waiver The degree to which services and planning incorporate the service recipient's voice. <u>"Acceptability"</u></p>	<p>Implement individualize treatment plan in collaboration with the consumer</p>	<p>There is there evidence that consumer had input into treatment plan. <input type="checkbox"/>YES <input type="checkbox"/>NO Consumer should have signed treatment plan.</p>
<p>2.WAC 275-57-410 (3) Individualized Plan</p>	<p>Plan shall be implemented within thirty days of initiating community support services.</p>	<p>Was plan implemented within 30 days. <input type="checkbox"/>YES <input type="checkbox"/>NO</p>
<p>3. WAC 275-57-410 (3)(a) adults</p> <p>"Medical Audit" Federal Waiver The degree to which there was inclusion , recruitment and use of natural supports and other community resources. <u>"Acceptability"</u></p> <p>"Medical Audit" Federal Waiver The degree to which services and planning incorporate the service recipient's voice. <u>"Acceptability"</u></p>	<p>For adults treatment plan is developed with the consumer and include people who provide active support to the consumer.</p>	<p>Is there evidence of others participation in the treatment plan. <input type="checkbox"/>YES <input type="checkbox"/>NO <input type="checkbox"/>NA Charting should indicate involvement of others especially if consumer is not living alone.</p>
<p>4. WAC 275-57-410 (3)(b)Children</p> <p>"Medical Audit" Federal Waiver The degree to which there was inclusion , recruitment and use of natural supports and other community resources. <u>"Acceptability"</u></p> <p>"Medical Audit" Federal Waiver The degree to which services and planning incorporate the service recipient's voice. <u>"Acceptability"</u></p>	<p>For children, develop the plan with the child, family and others who provide active support to the child.</p>	<p>There is evidence of family involvement or others. <input type="checkbox"/>YES <input type="checkbox"/>NO <input type="checkbox"/>NA Charting should indicated involvement of others especially family members or school.</p>
<p>5. WAC 275-57-410 (3)(b) children</p>	<p>For children under 3 the plan shall be integrated with the individualized family service plan (IFSP), when applicable.</p>	<p>For children under 3, plan is integrated with (IFSP) <input type="checkbox"/>YES <input type="checkbox"/>NO <input type="checkbox"/>NA If child is under three there should be an IFSP record in the chart.</p>

Justification	Standard	Compliance
---------------	----------	------------

6. WAC 275-57-410 (3) (c)(i) Needs	Treatment Plan focuses on normalization and addresses needs identified by the consumer which may include: Least restrictive housing	Did treatment plan address needs of consumer? <input type="checkbox"/> YES <input type="checkbox"/> NO
7. WAC 275-57-410 (3) (ii)	Treatment plan shall address income	Treatment plan addresses income <input type="checkbox"/> YES <input type="checkbox"/> NO
8. WAC 275-57-410 (3) (iii)	Treatment plan shall address work or school	Treatment plan addresses work or school <input type="checkbox"/> YES <input type="checkbox"/> NO
9. WAC 275-57-410 (3) (iv)	Treatment plan shall address social life	Treatment plan addresses social life <input type="checkbox"/> YES <input type="checkbox"/> NO
10. WAC 275-57-410 (3) (v)	Treatment shall include psychotherapy	There is evidence of ongoing psychotherapy in the treatment plan <input type="checkbox"/> YES <input type="checkbox"/> NO
11. WAC 275-57-410 (3) (d) Goals/time frames	Treatment plan links or comes to specific goals and time frames for achieving	Goals, outcome and time frames are identified in treatment plan <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A There should be specific dates for accomplishing goals
12. WAC 275-57-410 (3) (e) Services "Medical Audit" Federal Waiver The degree to which services provided are driven by recipient needs "Quality of Care"	The provider shall flexibly develop or purchase services to meet the unique needs of the person	Case record indicate that services go beyond categorical program and/or routine traditional mental health services <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
13. WAC 275-57-410 (3) (g) 180 day review	Treatment plan is mutually reviewed every six months, or more often at the request of the consumer.	Treatment plan (updates or reviews) has consumer signature or evidence of consumer involvement and done every 180 days. <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
14. WAC 275-57-410 (4) (a) Progress "Medical Audit" Federal Waiver The degree to which there is congruency between the chart including assessment, treatment plan, and progress notes and the actual services provided. "Quality of Care"	The provider shall periodically document consumer progress in achieving treatment goals in the case record.	Consumer records indicate documentation of progress towards goals in the progress notes. <input type="checkbox"/> YES <input type="checkbox"/> NO
15. WAC 275-57-410 (4) (b) Treatment goals- changes in Treatment Plan	The provider shall include specific progress toward established goals, changes in individualized plans and extraordinary events in the case record.	Consumer records indicate documentation of specific progress toward goals, changes in individualized plans and extraordinary events. <input type="checkbox"/> YES <input type="checkbox"/> NO
16. WAC 275-57-410 (4) (c)	A mental health professional shall review and sign off on: Intake; Individualize plan; revisions in plan.	There is a mental health professional signature on all required documents. <input type="checkbox"/> YES <input type="checkbox"/> NO

Justification	Standard	Compliance
---------------	----------	------------

CONSENT AND ACCESS TO TREATMENT RECORDS.

1. WAC 275-57-360 Confidential Information "Medical Audit" Federal Waiver The degree to which services and planning incorporate the service recipient's voice. <u>"Acceptability"</u>	The provider shall ensure information about the consumer is not shared or released except as specified by statute. Chapter 70.02, 71.05, and 71.34 RCW.	Records indicate information is not shared without consent. <input type="checkbox"/> YES <input type="checkbox"/> NO Consumer should sign a release of information if necessary.
2. WAC 275-57-350 (1) Consent to treatment (children)	Any minor over twelve years of age may request and receive treatment without the consent of the minor's parent.	Chart indicates minor over 12 and receiving treatment without consent of parent. <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NA
3. WAC 275-57-350 (4)(a) Informed consent "Medical Audit" Federal Waiver The degree to which services and planning incorporate the service recipient's voice. <u>"Acceptability"</u>	The provider shall obtain written informed consent of the consumer or legally responsible other before: (a) Use of medication	Informed consent obtained before use of medications. . <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NA
4. WAC 275-57-350(4)(b)	(b) Use of unusual diagnostic or treatment procedure	Informed consent required found in chart. <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NA
5. WAC 275-57-350(4)(c)	(c) Use of audio and/or visual devises to record consumer's behavior	Informed consent required and found in chart. <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NA
6. WAC 275-57-350(4)(d)	(d) The consumer serves as a subject for research.	Informed consent required and found in chart. <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NA

Justification	Standard	Compliance
---------------	----------	------------

SPECIAL POPULATIONS

<p>1. 275-57-320 (1) Child mental health specialist</p> <p>"Medical Audit" Federal Waiver The degree to which services and planning are age, culturally and linguistically competent. <u>"Acceptability"</u></p>	<p>The provider shall ensure services directed to children are provided by, under the supervision of or with consultation from a child mental health specialist.</p>	<p>Child specialist consult is required and case manager is a child specialist/or a consult from a child specialist can be found in the chart. <input type="checkbox"/>YES <input type="checkbox"/>NO <input type="checkbox"/>NA</p>
<p>2. 275-57-320 (2) Geriatric mental health specialist.</p> <p>"Medical Audit" Federal Waiver The degree to which services and planning are age, culturally and linguistically competent. <u>"Acceptability"</u></p>	<p>The provider shall ensure services directed to the elderly are provided by, under the supervision of, or with consultation from a geriatric mental health specialist.</p>	<p>Geriatric specialist consult is required and case manager is a Geriatric specialist/or a consult from a geriatric specialist can be found in the chart. <input type="checkbox"/>YES <input type="checkbox"/>NO <input type="checkbox"/>NA</p>
<p>3. 275-57-320 (3) Ethnic minority mental health specialist.</p> <p>"Medical Audit" Federal Waiver The degree to which services and planning are age, culturally and linguistically competent. <u>"Acceptability"</u></p>	<p>The provider shall ensure services directed to ethnic minority consumers are provided by, under the supervision of, or with consultation from an ethnic minority mental health specialist.</p>	<p>A minority consult is required and the case manager is a specialist for the following required groups or a consult can be found in the chart. <input type="checkbox"/>American Indian/Alaska Native. <input type="checkbox"/>African American <input type="checkbox"/>Asian/Pacific Islander <input type="checkbox"/>Hispanic <input type="checkbox"/>YES <input type="checkbox"/>NO <input type="checkbox"/>NA</p>
<p>4. 275-57-320 (4) Disability mental health specialist.</p> <p>"Medical Audit" Federal Waiver The degree to which services and planning are age, culturally and linguistically competent. <u>"Acceptability"</u></p>	<p>The provider shall ensure services directed to consumers with a disability shall be provided by, under the supervision of, or with consultation from a mental health specialist with special expertise in working with the disabled group.</p>	<p>Consult for a disability specialist is required and case manager is a disability specialist/or consult can be found in the chart. <input type="checkbox"/>YES <input type="checkbox"/>NO <input type="checkbox"/>NA</p>

Justification	Standard	Compliance
---------------	----------	------------

PSYCHIATRIC AND MEDICAL SERVICES

1. WAC 275-57-450 Psychiatric and Medical Services	Provider shall provide psychiatric and medical services to ensure consumers are prescribed medications when necessary.	Medications are prescribed by the provider. <input type="checkbox"/> YES <input type="checkbox"/> NO If no, skip this section and do not score.
2. WAC 275-57-450	Consumer is knowledgeable about medications and side effects.	Consumer has signed medication consent and consent includes information about side effects of medications. <input type="checkbox"/> YES <input type="checkbox"/> NO Consumer should be aware of the side effect for each medication. Generally one would expect to see some documentation indicating awareness of each medication.
3. WAC 275-57-450 (1)	Provider shall vest overall medical responsibility in a physician licensed to practice under Chapter 18.57 or 18.71 RCW and board eligibility in psychiatry	Provider has psychiatrist assigned. <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NA Note: If provider does not have a psychiatrist assigned but meets the requirement below, please check NA for this area.
4. WAC 275-57-450(a)(b)	If provider is unable to recruit a psychiatrist, they may employ physician without board eligibility provided: Psychiatric consultation is provided to the physician at least monthly; and (b) A psychiatrist is accessible in person by telephone, or by radio communication to the physician for emergency consultation.	Provider does not have a psychiatrist assigned but consultation is provided to the physician at least monthly and a psychiatrist is accessible (pager and telephone number) for emergency consultation. <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NA
5. WAC 275-57-450 (2) "Medical Audit" Federal Waiver Credentialing of clinical staff "Quality of Care"	Only licensed staff may prescribe medications.	Medications are prescribed by licensed staff. <input type="checkbox"/> YES <input type="checkbox"/> NO Only a licensed staff can prescribe medication. This include psychiatrist, MD, AARNP.
6. WAC 275-57-450 (2)	Prescribing staff shall review medications at least every 3 months.	Records indicate medications were reviewed monthly at least every 3 months.. <input type="checkbox"/> YES <input type="checkbox"/> NO
7. WAC 275-57-450 (3) "Medical Audit" Federal Waiver Credentialing of clinical staff "Quality of Care"	Only staff licensed to do so may administer medications.	Records indicate medications are administered by licensed staff.(ARRNP, RN, LPN, psychiatrist) <input type="checkbox"/> YES <input type="checkbox"/> NO

Justification	Standard	Compliance
---------------	----------	------------

PSYCHIATRIC AND MEDICAL SERVICES CON'T.

8. WAC 275-57-450 (5)(a)	The provider shall maintain medication information in the consumer record.	Consumer is receiving medications and there is a medication record. <input type="checkbox"/> YES <input type="checkbox"/> NO
9. WAC 275-57-450 (5) (b)	Name and purpose of medication is documented.	Name and purpose of medication is documented. <input type="checkbox"/> YES <input type="checkbox"/> NO
10. WAC 275-57-450 (5)(c)	Dosage and method of administration is documented.	Dosage and method of administration is documented. <input type="checkbox"/> YES <input type="checkbox"/> NO
11. WAC 275-57-450 (5)(c)	Dates prescribed, reviewed, and/or renewed is documented.	Dates prescribed, reviewed and/or renewed is documented. <input type="checkbox"/> YES <input type="checkbox"/> NO
12. WAC 275-57-450 (5)(d)	Observed and reported side effects are documented.	Records indicate documentation of side effects. <input type="checkbox"/> YES <input type="checkbox"/> NO
13. WAC 275-57-450 (5)(e)	Laboratory findings are documented.	Laboratory findings are documented <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NA All medications do not require lab results.
14. WAC 275-57-450 (5)(f)	Reason for change or termination of medication is documented.	Reason for change or termination is documented. <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NA
15. WAC 275-57-450 (5)(g)	Name and signature of person prescribing medication is documented.	Name and signature of person prescribing person is documented. <input type="checkbox"/> YES <input type="checkbox"/> NO
16. WAC 275-57-450 (6) Medical Treatment	Provider shall consult with and/or offer to make referral to a physician when physical health problems are suspected and include current medical concerns in individualized treatment plan as necessary.	Records indicate the need to make referral to a physician and a referral was made. <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NA If referral was made there should be a signed consent.

Justification	Standard	Compliance
---------------	----------	------------

BRIEF INTERVENTION SERVICES

1. WAC 275-57-400 (1) Brief Intervention Services	The RSN shall define the number of allowable brief interventions services.	The number of allowable brief intervention services is defined/established in the chart. YES NO INA
2. WAC 275-57-400 (2) Brief Interventions Services	A person receiving more than fifteen hours of service in a twelve month shall receive a full intake evaluation.	Consumer received more than 15 hours of service in a 12 month period and a full intake was completed. YES NO INA
3. WAC 275-57-400 (3)(a) Brief Interventions Services	The provider of brief intervention services shall gather the following information in the intake to brief interventions: Mental Status examination.	Mental Status examination completed. YES NO INA
4. WAC 275-57-400 (3)(b) "Medical Audit" Federal Waiver The degree to which services provided are driven by recipient needs. "Quality of Care"	Intake shall address functioning in daily life domains showing strengths as well as needs.	Functions in daily life domains showing strengths as well as needs are identified. YES NO INA
5. WAC 275-57-400 (3)(c)	Intake shall address substance use and abuse.	Information on drug use/abuse is addressed. YES NO INA
6. WAC 275-57-400 (3)(d)	The intake shall include the name of the consumer's most recent physician and prescribed medications.	Name of the most recent physician and prescribed medications are identified. YES NO INA
7. WAC 275-57-400 (3)(e) "Medical Audit" Federal Waiver The degree to which services and planning incorporate the service recipient's voice. "Acceptability"	The intake shall contain brief plan of action to achieve mutually agreed upon outcomes.	Plan of action contains identifies mutually agreed upon outcomes. YES NO INA Consumer signature, case manager, quotes consumer.
8. WAC 275-57-400 (3)(f)	Seeking of intake information shall not present a barrier to services.	If information left out of intake, reason for incomplete information is documented. YES NO INA The intake should be complete but consumer may not want to address all the issues and this should be noted in the chart.

Justification	Standard	Compliance
---------------	----------	------------

SUPPORTED EMPLOYMENT

1. WAC 275-57-440 (1) (a) Community Support Services- Employment Services "Medical Audit" Federal Waiver The degree to which needs for housing, employment and education options are assessed and support and services provided <u>"Quality of Care"</u>	Provide age and culturally appropriate employment as a treatment option for consumers wanting to work.	Consumer is employed. <input type="checkbox"/> YES <input type="checkbox"/> NO Is the agency licensed to and providing these supported employment services? YES NO Does the RSN contract for these services with the agency? YES NO Is DVR involved? <input type="checkbox"/> YES <input type="checkbox"/> NO If no on questions above- skip this section and do not score!
2. WAC 275-57-440 (1) (a)	Consumer records contain a vocational assessment of work history, skills training, education and personal career goals.	Records contain vocational assessment. <input type="checkbox"/> YES <input type="checkbox"/> NO
3.. WAC 275-57-440 (1) (b)	Consumer records contain public assistance information.	Records contain information about public assistant information. <input type="checkbox"/> YES <input type="checkbox"/> NO
4. WAC 275-57-440 (1) (c)	There shall be active involvement with consumer in establishing individualized job and career development plans.	Records indicate employment is part of individualized plan. <input type="checkbox"/> YES <input type="checkbox"/> NO
5. WAC 275-57-440 (1) (d)	Provider shall assist consumer in locating employment consistent with consumer skills, goals and interest.	Records indicate assistance was provided in helping locate employment. <input type="checkbox"/> YES <input type="checkbox"/> NO
6. WAC 275-57-440 (1) (e)	Consumer records indicate integration of supported employment including outreach and support services in the place of employment, if required.	Records indicate integration of supported employment. <input type="checkbox"/> YES <input type="checkbox"/> NO
7. WAC 275-57-440 (1) (f)	Consumers records indicate case manager interaction with employer to maintain stability and employment and ADA compliance.	Records indicate case manager interacts with employer. <input type="checkbox"/> YES <input type="checkbox"/> NO
8. WAC 275-57-440 (2)(a)(b)	If the RSN or service provider employee the consumer then the consumer is paid in accordance with the Fair Labor and Standards Act and safety standards are in place in full compliance with local and state regulations.	Records indicate consumer is paid minimum wage. <input type="checkbox"/> YES <input type="checkbox"/> NO

Justification	Standard	Compliance
---------------	----------	------------

CASE MANAGEMENT SERVICES

1. WAC 275-57-420 Case Management	RSN or designee shall provide case management services.	Tx. Plan declares C.M is needed. <input type="checkbox"/> YES <input type="checkbox"/> NO Assessment declares or indicates C.M is needed. <input type="checkbox"/> YES <input type="checkbox"/> NO Progress notes indicate C.M. is being provided. <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If NO on all three above skip this section and do not score!</i>
2. WAC 275-57-420 "Medical Audit" Federal Waiver The degree to which there was inclusion , recruitment and use of natural supports and other community resources. <u>"Acceptability"</u> "Medical Audit" Federal Waiver The degree to which there are appropriate linkages and integration with other systems and settings. <u>"Acceptability"</u>	Case management services shall include outreach and support to achieve the individualized plan's outcomes.	Records indicate outreach and support is needed and being provided. <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NA There may be evidence in the chart indicating the consumer is homeless, unable to make schedule appointments and etc. There should be some documentation in the chart as to how case manager will attempt to help consumer.
3. WAC 275-57-420 (i) "Medical Audit" Federal Waiver The degree to which needs for housing, employment and education options are assessed and support and services provided <u>"Acceptability"</u>	Case management addresses housing.	Records indicate housing is a consumer need and that cultural consideration were addressed for housing. <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NA <i>If record does not indicate a need, there should be reference in the chart about where the consumer is residing.</i>
4. WAC 275-57-420 (ii)	Case management addresses Food.	Records indicate that consumer expressed special or unique dietary needs and they were addressed. <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NA <i>Records should indicate the consumer has been asked about daily eating habits and the physical appearance may be addressed such as appear malnourish or appear overweight.</i>
5. WAC 275-57-420 (iii)	Case management addresses income.	Records indicate that state and federal entitlements were discussed with the consumer. <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NA

Justification	Standard	Compliance
6. WAC 275-57-420 (iv)	Case management addresses Health and dental care.	Records indicate the consumer physical health and dental has been discussed/assessed. <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NA <i>There should be documentation referencing consumer health and dental care needs. If there are needs, has the case manager made plans to address those needs(i.e. referral?)</i>
7. WAC 275-57-420 (v)	Case management addresses transportation.	Records indicate transportation needs for the consumer were addressed <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NA If consumer has problems with making scheduled appointments, is a reason given and does it involve transportation ? If it does involve transportation, has case manager addressed the topic.
8. WAC 275-57-420 (b) "Medical Audit" Federal Waiver The degree to which services and planning are age, culturally and linguistically competent. <u>"Acceptability"</u>	Case management addresses work or other daily activities appropriate to the consumer's age and culture.	Employment, school, daily activities and etc. were discussed/assessed. <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NA There should be some reference in the consumer's chart about what kind of work the consumer does and if the consumer does not work there should be some information about what the consumer does during the day.
9. WAC 275-57-420 (c) "Medical Audit" Federal Waiver The degree to which there are appropriate linkages and integration with other systems and settings. <u>"Acceptability"</u>	Case management services link the consumer to the regular social life of the community.	Integration in to the community was discussed/assessed with the consumer. <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NA <i>There should be some reference in the chart indicating contact with community and plans for support in the community.</i>

Justification	Standard	Compliance
<p>10. WAC 275-57-420 (d)</p> <p>"Medical Audit" Federal Waiver The degree to which there are appropriate linkages and integration with other systems and settings. <u>"Acceptability"</u></p>	<p>Case management services provide access to other needed services, such as substances abuse and health care.</p>	<p>Records indicate other needed services were discussed with the consumer (substance abuse/health care). <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NA <i>There should be documentation referencing the consumer use/abuse of substance. Example: consumer is a moderate drinker and/or has used drugs in the past.</i></p>
<p>11. WAC 275-57-420 (e)</p>	<p>Resolve crises in least-restrictive settings.</p>	<p>Records indicate discussion of potential crisis has occurred and/or crisis plan provides for lesser restrictive setting. <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NA If crisis services have not been provided "skip" and mark NA. There should be documentation about how potential crisis should be resolved. Consumer may have a crisis plan in chart. Plan should have some input from the consumer and what plans the consumer has in the event of a crisis.</p>
<p>12. WAC 275-57-420 (f)</p>	<p>Manage symptoms by providing information and education about the consumer's illness and treatment.</p>	<p>Records indicate consumer was educated about illness. <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NA Should be able to locate documentation that consumer illness and treatment was discussed with them. Are brochures given to consumer? Medication plans should address this issue in part.</p>
<p>13. WAC 275-57-420 (2)</p> <p>"Medical Audit" – Federal Waiver The degree to which there was inclusion, recruitment and use of natural supports and other community resources. <u>"Acceptability"</u></p>	<p>Assist family members and other care givers in their efforts to support and care for the consumer.</p>	<p>Records indicate discussions with family members and others were occurring and that support was being provided <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NA</p>

Justification	Standard	Compliance
---------------	----------	------------

14. WAC 275-57-420 (3)	Include, as necessary, flexible applications of funds.	Indicators would include funds spent for rent subsidies, in-home care, utilities, cleaning, food, etc. <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NA If a consumer require use of flexible funds, it should be documented and what the funds should be used for. Has agency followed its own policy and procedure in this case?
15. WAC 275-57-420 (4)	Provide services where and when needed.	Record indicates that services were provided out of facility <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NA

Justification	Standard	Compliance
---------------	----------	------------

CRISIS RESPONSE SERVICES

1. WAC 275-57-390	The RSN, or its designee shall provided an integrated crisis response system twenty-four-hours-a-day and seven days a week, serving persons of all ages and cultures in crisis	Provider is licensed for Crisis Response. <input type="checkbox"/> YES <input type="checkbox"/> NO If No, skip this section.
2. WAC 275-57-390 "Medical Audit" Federal Waiver Triage for all settings of care (inpatient, urgent care, and outpatient services and supports) <u>"Access"</u>	When direct intervention is necessary, the RSN shall when possible, bring services directly to the persons in crisis, stabilizing and supporting the persons until the crisis is resolved or a referral is made.	Record indicates that crisis services were provided at a location where they were needed. <input type="checkbox"/> YES <input type="checkbox"/> NO <i>Policy should include stabilization, outreach, and referral.</i>
3. WAC 275-57-390 (2)(a)(i)(ii)	Ensure the least restrictive resolution of the crisis by providing the following services twenty-four-hours-a-day. Initial screening and assessment to determine whether crisis has a mental disorder basis, and course of action to resolve crisis	The record indicates that an in initial screening occurred and included the following Whether the crisis had a mental disorder Course of action to resolve the crisis Mobile outreach to conduct face-to-face evaluations Mobile outreach to provide in-home services or in-community stabilization services <input type="checkbox"/> YES <input type="checkbox"/> NO <i>There should be an assessment form and the assessment should indicate whether the crisis has a mental disorder basis, steps to resolve crisis should be noted. Example: may contact case manager, or refer to clinic for medications.</i> <i>There should be a mobile outreach team and the team should have qualified staff to conduct face to face evaluations and the qualifications include the ability to make decisions about in home service and flexible support to stabilize until the crisis is resolved.</i> <i>May want to look at the team makeup.</i>
4. WAC 275-57-390 (A)(B)(C)(D)	Access to medical services include Emergency medical services; Preliminary screening or organic disorders; Prescription services; and Medication administration.	The record indicated that any of the following services were accessed or assessable: Emergency medical services Screening for organic disorders Prescription services Medication administration <input type="checkbox"/> YES <input type="checkbox"/> NO If the services are not readily available within the crisis response team then there are other means for accessing these services.

Justification	Standard	Compliance
5. WAC 275-57-390 (ii)	Crisis response services has interpretative services available enabling staff to communicate with persons who are limited English proficient.	The record indicated a need for consumer access to interpretative services and that these services were provided. <input type="checkbox"/> YES <input type="checkbox"/> NO <i>Provider may have interpreters on contract and the crisis team should know how to access interpreters. This may be in the form of a policy for crisis team.</i>
6. WAC 275-57-390 (2)(d)	Crisis team has access to Investigation and detention services (chapters 71.05 and 71.34 RCW).	The record indicated that a County Designate Mental Health Professional was involved. <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NA Crisis team should be able to access the CDMHP. Is there a written policy for accessing the CDMHP and does policy provide for 24 hour access to CDMHP.
7. WAC 275-57-390 (3) "Medical Audit" Federal Waiver The degree to which there was inclusion , recruitment and use of natural supports and other community resources. <u>"Acceptability"</u>	Engage family, significant others, and other relevant treatment providers as necessary to provide support to the person in crisis.	The record indicated that family, significant others and other relevant treatment providers were engaged when needed. <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NA There should be documentatic i about when and who should be contacted in the event of a crisis. This information may be found on the individual crisis plan. There should be an agency policy that addresses this.
8. WAC 275-57-390 (4)	Document all telephone and face-to face contacts to include Source of referral Nature of crisis Time elapsed from initial contact to response Outcomes including Follow up Referrals	The record, crisis log or combination of such documents that this information is being recorded/tracked. <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NA

Attachment B.V15

Chapter 47.06B RCW
COORDINATING SPECIAL NEEDS TRANSPORTATION

SECTIONS

47.06B.010	Finding -- Intent
47.06B.012	Definitions.
47.06B.015	Program for Agency Coordinated Transportation.
47.06B.020	Agency council on coordinated transportation -- Creation, membership, staff.
47.06B.030	Council -- Duties (as amended by 1999 c 372).
47.06B.030	Council -- Duties (as amended by 1999 c 385)
47.06B.040	Local planning forums.
47.06B.900	Council -- Termination.
47.06B.901	Repealer.

RCW 47.06B.010 Finding -- Intent.
(Effective until June 30, 2008.)

The legislature finds that transportation systems for persons with special needs are not operated as efficiently as possible. In some cases, programs established by the legislature to assist persons with special needs can not be accessed due to these inefficiencies and coordination barriers.

It is the intent of the legislature that public transportation agencies, pupil transportation programs, private nonprofit transportation providers, and other public agencies sponsoring programs that require transportation services coordinate those transportation services. Through coordination of transportation services, programs will achieve increased efficiencies and will be able to provide more rides to a greater number of persons with special needs.

[1999 c 385 § 1; 1998 c 173 § 1.]

RCW 47.06B.012 Definitions.
(Effective until June 30, 2008.)

The definitions in this section apply throughout this chapter.

- (1) "Persons with special transportation needs" means those persons, including their personal attendants, who because of physical or mental disability, income status, or age are unable to transport themselves or purchase transportation.
- (2) "Special needs coordinated transportation" is transportation for persons with special transportation needs that is developed through a collaborative community process involving transportation providers; human service programs and agencies; consumers; social, educational, and health service providers; employer and business representatives; employees and employee representatives; and other affected parties.

[1999 c 385 § 2.]

**RCW 47.06B.015 Program for Agency Coordinated Transportation
(Effective until June 30, 2008.)**

In order to increase efficiency, to reduce waste and duplication, to enable people to access social and health services, to provide a basic level of mobility, and to extend and improve transportation services to people with special transportation needs, the state shall implement the Program for Agency Coordinated Transportation. The program will improve transportation efficiency and effectiveness to maximize the use of community resources so that more people can be served within available funding levels.

The Program for Agency Coordinated Transportation will facilitate a state-wide approach to coordination and will support the development of community-based coordinated transportation systems that exhibit the following characteristics:

- (1) Organizations serving persons with special transportation needs share responsibility for ensuring that customers can access services.
- (2) There is a single entry process for customers to use to have trips arranged and scheduled, so the customer does not have to contact different locations based on which sponsoring agency or program is paying for the trip.
- (3) A process is in place so that when decisions are made by service organizations on facility siting or program policy implementation, the costs of client transportation and the potential effects on the client transportation costs of other agencies or programs are considered. Affected agencies are given an opportunity to influence the decision if the potential impact is negative.
- (4) Open local market mechanisms give all providers who meet minimum standards an opportunity to participate in the program, and, in addition, allow for cost comparisons so that purchasers can select the least expensive trip most appropriate to the customer's needs.
- (5) There is flexibility in using the available vehicles in a community so that the ability to transport people is not restricted by categorical claims to vehicles.
- (6) There is maximum sharing of operating facilities and administrative services, to avoid duplication of costly program elements.
- (7) Trip sponsors and service providers have agreed on a process for allocating costs and billing when they share use of vehicles.
- (8) Minimum standards exist for at least safety, driver training, maintenance, vehicles, and technology to eliminate barriers that may prevent sponsors from using each other's vehicles or serving each other's clients.

- (9) The system is user friendly. The fact that the system is supported by a multitude of programs and agencies with different eligibility, contracting, service delivery, payment, and funding structures does not negatively affect the customer's ability to access service.
- (10) Support is provided for research, technology improvements, and sharing of best practices from other communities, so that the system can be continually improved.
- (11) There are performance goals and an evaluation process that leads to continuous system improvement.

[1999 c 385 § 3.]

RCW 47.06B.020 Agency council on coordinated transportation -- Creation, membership, staff.
(Effective until June 30, 2004.)

- (1) The agency council on coordinated transportation is created. The council is composed of nine voting members and eight nonvoting, legislative members.
- (2) The nine voting members are the superintendent of public instruction or a designee, the secretary of transportation or a designee, the secretary of the department of social and health services or a designee, and six members appointed by the governor as follows:
 - (a) One representative from the office of the governor;
 - (b) Two persons who are consumers of special needs transportation services;
 - (c) One representative from the Washington association of pupil transportation;
 - (d) One representative from the Washington state transit association; and
 - (e) One of the following:
 - (i) A representative from the community transportation association of the Northwest; or
 - (ii) A representative from the community action council association.
- (3) The eight nonvoting members are legislators as follows:
 - (a) Four members from the house of representatives, two from each of the two largest caucuses, appointed by the speaker of the house of representatives, two who are members of the house transportation policy and budget committee and two who are members of the house appropriations committee; and
 - (b) Four members from the senate, two from each of the two largest caucuses, appointed by the president of the senate, two members of the transportation committee and two members of the ways and means committee.
- (4) Gubernatorial appointees of the council will serve two-year terms. Members may not receive compensation for their service on the council, but will be reimbursed for actual

and necessary expenses incurred in performing their duties as members as set forth in RCW 43.03.220.

- (5) The secretary of transportation or a designee shall serve as the chair.
- (6) The department of transportation shall provide necessary staff support for the council.
- (7) The council may receive gifts, grants, or endowments from public or private sources that are made from time to time, in trust or otherwise, for the use and benefit of the purposes of the council and spend gifts, grants, or endowments or income from the public or private sources according to their terms, unless the receipt of the gifts, grants, or endowments violates RCW 42.17.710.

[1998 c 173 § 2.]

**RCW 47.06B.030 Council – Duties (as amended by 1999 c 385).
(Effective until June 30, 2008.)**

To assure implementation of the Program for Agency Coordinated Transportation, the council, in coordination with stakeholders, shall:

- (1) Develop guidelines for local planning of coordinated transportation in accordance with this chapter;
- (2) Initiate local planning processes by contacting the board of commissioners and county councils in each county and encouraging them to convene local planning forums for the purpose of implementing special needs coordinated transportation programs at the community level;
- (3) Work with local community forums to designate a local lead organization that shall cooperate and coordinate with private and nonprofit transportation brokers and providers, local public transportation agencies, local governments, and user groups;
- (4) Provide a forum at the state level in which state agencies will discuss and resolve coordination issues and program policy issues that may impact transportation coordination and costs;
- (5) Provide guidelines for state agencies to use in creating policies, rules, or procedures to encourage the participation of their constituents in community-based planning and coordination, in accordance with this chapter;
- (6) Facilitate state-level discussion and action on problems and barriers identified by the local forums that can only be resolved at either the state or federal level;
- (7) Develop and test models for determining the impacts of facility siting and program policy decisions on transportation costs;

- (8) Develop methodologies and provide support to local and state agencies in identifying transportation costs;
- (9) Develop guidelines for setting performance measures and evaluating performance;
- (10) Develop monitoring reporting criteria and processes to assess state and local level of participation with this chapter;
- (11) Administer and manage grant funds to develop, test, and facilitate the implementation of coordinated systems;
- (12) Develop minimum standards for safety, driver training, and vehicles, and provide models for processes and technology to support coordinated service delivery systems;
- (13) Provide a clearinghouse for sharing information about transportation coordination best practices and experiences;
- (14) Promote research and development of methods and tools to improve the performance of transportation coordination in the state;
- (15) Provide technical assistance and support to communities;
- (16) Facilitate, monitor, provide funding as available, and give technical support to local planning processes;
- (17) Form, convene, and give staff support to stakeholder work groups as needed to continue work on removing barriers to coordinated transportation;
- (18) Advocate for the coordination of transportation for people with special transportation needs at the federal, state, and local levels;
- (19) Recommend to the legislature changes in laws to assist coordination of transportation services;
- (20) Petition the office of financial management to make whatever changes are deemed necessary to identify transportation costs in all executive agency budgets;
- (21) Report to the legislature by December 2000, on council activities including, but not limited to, the progress of community planning processes, what demonstration projects have been undertaken, how coordination affected service levels, and whether these efforts produced savings that allowed expansion of services. Reports must be made once every two years thereafter, and other times as the council deems necessary.

[1999 c 385 § 5; 1998 c 173 § 3.]

RCW 47.06B.040 Local planning forums.
(Effective until June 30, 2008.)

The council may request, and may require as a condition of receiving coordination grants, selected county governments to convene local planning forums and invite participation of all entities, including tribal governments, that serve or transport persons with special transportation needs. Counties are encouraged to coordinate and combine their forums and planning processes with other counties, as they find it appropriate. The local community forums must:

- (1) Designate a lead organization to facilitate the community planning process on an ongoing basis;
- (2) Identify functional boundaries for the local coordinated transportation system;
- (3) Clarify roles and responsibilities of the various participants;
- (4) Identify community resources and needs;
- (5) Prepare a plan for developing a coordinated transportation system that meets the intent of this chapter, addresses community needs, and efficiently uses community resources to address unmet needs;
- (6) Implement the community coordinated transportation plan;
- (7) Develop performance measures consistent with council guidelines;
- (8) Develop a reporting process consistent with council guidelines;
- (9) Raise issues and barriers to the council when resolution is needed at either the state or federal level;
- (10) Develop a process for open discussion and input on local policy and facility siting decisions that may have an impact on the special needs transportation costs and service delivery of other programs and agencies in the community.

[1999 c 385 § 6.]

RCW 47.06B.900 Council--Termination.

The agency council on coordinated transportation is terminated on June 30, 2007, as provided in RCW 47.06B.901.

[1999 c 385 § 7; 1998 c 173 § 6.]

RCW 47.06B.901 Repealer.

The following acts or parts of acts, as now existing or hereafter amended, are each repealed, effective June 30, 2008:

- (1) RCW 47.06B.010 and 1999 c 385 § 1 & 1998 c 173 § 1;
- (2) RCW 47.06B.012 and 1999 c 385 § 2;
- (3) RCW 47.06B.015 and 1999 c 385 § 3;
- (4) RCW 47.06B.020 and *1999 c 385 § 4 & 1998 c 173 § 2;
- (5) RCW 47.06B.030 and 1999 c 385 § 5 & 1998 c 173 § 3; and
- (6) RCW 47.06B.040 and 1999 c 385 § 6.

[1999 c 385 § 8; 1998 c 173 § 7.]

NOTES:

***Reviser's note:** 1999 c 385 § 4 was vetoed.

Draft 4
ADMINISTRATIVE POLICY NO. 8.09

SUBJECT: Coordinated Special Needs Transportation Services

INFORMATION CONTACT: Non-Emergency Medical Transportation Program, Medical Assistance Administration, Division of Client Support, Transportation & Interpreter Services Section
MS 45534 (360) 725-1312; TTY (800) 848-5429

AUTHORIZING SOURCE: RCW 47.06B.030(5)

EFFECTIVE DATE: July 1, 2001

REVISED:

APPROVED BY: _____
Assistant Secretary for Management Services

SUNSET REVIEW DATE: June 30, 2007

CROSS REFERENCE:

For non-emergent medical transportation, see WAC 388-546-5000 through 388-546-5500.

PURPOSE:

To ensure all DSHS Administrations support special needs coordinated transportation for persons with special transportation needs. All Administrations will work cooperatively to coordinate transportation services to ensure all eligible DSHS clients have access to covered services. Through coordination, DSHS will ensure transportation services are:

- Safe,
- Efficient,
- Cost effective, and
- Appropriate to the needs of DSHS clients.

SCOPE:

This policy applies to all DSHS:

- Administrations, Divisions, Sections, and Units; and

BVI5

- Transportation services provided to and for persons with special transportation needs as defined by chapter 47.06B RCW, whether those services are delivered by DSHS staff or by a DSHS contracted vendor.

BACKGROUND:

Chapter 47.06B RCW was amended in 1999, and states in part:

“It is the intent of the legislature that...public agencies sponsoring programs that require transportation services coordinate those transportation services. Through coordination of services, programs will achieve increased efficiencies and will be able to provide more rides to a greater number of persons with special needs.” RCW 47.06B.010

DEFINITIONS:

The Agency Council on Coordinated Transportation (ACCT) – Was created by, authorized by and implements chapter 47.06B RCW. ACCT is the formal decision making body that is charged with making regular reports to the legislature regarding compliance with chapter 47.06B RCW.

Contractor – An individual or agency that enters a contractual agreement with the department to provide specific services for a fee or rate.

Department – Department of Social and Health Services.

The Program for Agency Coordinated Transportation (PACT) – Is authorized by RCW 47.06B.015. PACT is responsible for improving access to social and health services and increasing efficiencies of transportation services for persons with special transportation needs, through coordination of transportation services.

PACT Forum – A forum for state agency representatives to discuss and resolve coordination and program policy issues that may impact transportation coordination for persons with special transportation needs. The PACT Forum serves as the formal work group for the ACCT.

Persons With Special Transportation Needs – Those persons who because of physical or mental disability, income status, or age are unable to transport themselves or purchase transportation.

Program – Any service unit of the department that designs, schedules, plans or administers services for department clients.

Service Provider – An individual or an agency:

- Contracted to provide the amount and kind of services requested by the department; and
- Providing services only to those individuals determined eligible by the department;
-OR-
- Providing services authorized by the department on a fee-for-service or per-unit basis.

Special Needs Coordinated Transportation – Transportation for persons with special transportation needs (and their personal attendants) that is developed through a collaborative community process involving transportation providers; human service programs and agencies; consumers; social, educational, and health service providers; employer and business representatives; employees and employee representatives; and other affected parties. (RCW 47.06B.012)

POLICY:

- A. To ensure Administrative compliance by January 1, 2002:
1. Each Administration, Division, Section, and Unit must make available information on special needs coordinated transportation to persons with special transportation needs when they access covered department programs.
 2. Each Administration must have in place written policies and procedures that are consistent with this policy.
- B. To develop and manage new and ongoing programs, each Administration:
1. Will assess the potential effects on persons with special transportation needs when making programmatic, policy, or service changes that may affect the ability of persons with special transportation needs to access department services. Administrations should include transportation providers, service agencies, and stakeholders when assessing these potential effects.
 2. Will consider allowing staff to participate in local community transportation forums to help develop special needs coordinated transportation options for persons with special transportation needs.
 3. Must designate a representative to participate in the PACT Forum, and encourage participation in PACT work groups as necessary.
 4. Should evaluate the potential effects on persons with special transportation needs when siting new facilities for programs (or when contracting with department services providers) that directly provide services for persons with special transportation needs.

5. Should consider contractual incentives to help ensure transportation services are coordinated to the extent practical when contracting for services that will be available for persons with special transportation needs. Example: Giving bonus points to bidders that can document a history of providing coordinated transportation services or have a history of participation in coordination activities.
6. Should develop tracking mechanisms to document and report all identified costs of providing transportation for persons with special transportation needs, according to parameters defined by the Office of Financial Management.
7. Must have client transportation grievance procedures. Administrations may incorporate this requirement into existing policies or procedures.
8. Must have written procedures specifying how persons with special transportation needs are going to be provided with information on special needs coordinated transportation.

C. Annual Reporting Requirements:

- I. Each Administration must submit an initial written report to the DSHS Deputy Secretary by June 30, 2002. The initial report will contain a summary of each Administration's current status of compliance with Policy No. 8.09.

At a minimum, the initial report must include the following headings:

- Status of Compliance to Administrative Policy No. 8.09.
- Identified Barriers to Policy No. 8.09.
- Action Plan to Remove Barriers to Policy No. 8.09. and
- Comments.

**MENTAL HEALTH DIVISION
POLICIES AND PROCEDURES**

Approved by (signature on file)
Karl Brimner, Director
Date issued: July 1, 2001

Effective Date: July 1, 2001

**POLICY STATEMENT NO. 4.03 SUBJECT: TRANSPORTATION FOR SERVICE
RECIPIENTS WITH SPECIAL NEEDS**

I. PURPOSE

The purpose of this policy is to outline the guidelines for processing transportation requests for Medicaid service recipients with special needs.

Reference: DSHS Administrative Policy No. 8.09

II. SCOPE

This policy applies to employees of the Mental Health Division (MHD) Central Office.

III. POLICY

It is the policy of the to ensure that Medicaid service recipients with special needs are afforded appropriate transportation to access non-emergent mental health services through existing mental health providers in their geographic area.

IV. PROCEDURE

The MHD Director will designate an individual to act as the Transportation Manager for reviewing requests for transportation for Medicaid service recipients with special needs. The MHD Transportation Manager will utilize the following procedures in reviewing transportation exception requests submitted by mental health providers:

OUTPATIENT

Transportation for Mental Health Medicaid recipients is authorized to or from a "Type 73" Medicaid provider (See License Directory). Type 73 refers to outpatient Mental Health Division (MHD) licensed facilities. Be alert regarding facilities which have program names designed to conceal the relationship to a Type 73 provider, to make the program more palatable to clients (e.g., Sunshine House, Strawberry Fields, Club Northwest, etc.) Transportation will be covered for Type 73 activities, including the initial intake, limited to one round trip per day. (These trips are billed directly to MAA.)

2 11 6

INPATIENT

Occasionally, an individual may voluntarily self-admit to a psychiatric ward in a hospital or acute care facility. In this case, if transportation is not available, or if the individual feels incapable of driving, then submit a **transportation exception request for transport** of this Medicaid recipient to an inpatient facility through MHD. If the Broker is informed that the individual has uncontrollable behaviors, then contact the local county designated Mental Health Professional (CDMHP). It is then permissible to refer those clients to Involuntary Treatment Admission Services.

GROUP THERAPY

Transportation to group therapy at a Mental Health Center may **not** be authorized for other people identified in the recipient's therapy plan except when a minor (under 18 years of age) is in either an inpatient or outpatient facility. In this situation, transportation to and from either an inpatient or outpatient facility may be authorized for family group members identified in the recipient's therapy plan. (These trips are billed directly to MAA.)

SOCIAL ACTIVITIES, PREVOCATIONAL TRAINING

Do not transport to social activities such as thanksgiving dinners/Christmas parties even if they are considered part of the patient's therapy plan.

Group or single trips to swimming pools, ceramics classes, physical fitness. Activities such as shopping malls, GED, social activities and the like will also be denied and are the responsibility of the center to provide.

ADULT DAY TREATMENT

Not to be confused with Adult Day Health, this program is a maintenance program designed to keep individuals from institutionalization. The Medical Assistance Administration **will** transport to and from these programs; however, transportation is **limited to one round trip per day**. Off site therapy is the responsibility of the provider.

CLUBHOUSES

The clubhouse model is in place in several areas around the state. If a recipient is attending a valid "approved clubhouse" (see bullets below), then rules relating to prevocational therapy, socialization, etc., are relaxed. Clubhouses provide on-site counseling therapy. Validate with approved listing, or check with MHD Transportation Manager at (360) 902-0823.

- Valid Clubhouses have a Vocational or Mental Health Therapist on-site.
- Valid Clubhouses are co-located with a licensed Mental Health Center.

Transportation may be provided to either a clubhouse or a Community Mental Health Center, limited to one round trip a day. (See approved clubhouse listing. These trips are billed directly to MAA.)

NOTE: Transportation from the clubhouse to other activities is the responsibility of the center and will not be provided by the Broker.

PSYCHIATRIC EVALUATION

Court-ordered psychiatric evaluations are not covered by medical coupons and are not eligible for transportation; however, if a physician refers an individual for psychiatric evaluation it can be covered by medical coupon (if the psychiatrist is enrolled with the Medical Assistance Administration (MAA), and therefore eligible for transportation).

USE OF TRANSIT

Community Mental Health Centers, while charged with the obligation to encourage independence, are also charged with the obligation to provide therapy. The broker can assist the center by providing transportation to the therapy, and assist recipients by working with the centers to identify recipients capable of using transit. Eligible recipients can be given a monthly bus pass. In some cases, where the center is concerned that the recipient may not attend therapy, it is permissible to arrange transportation to the program and allow the buss pass to be used to return home from therapy. This, in effect, will allow the recipient a greater freedom for other activities, ensure that therapy needs are met, and result in cost savings.

DOCUMENTATION

The Division of Mental Health is financially responsible for Medicaid Transportation Exception requests to include ITA. All trips and costs data must be documented and approved to charge the DMH. This must be submitted to the MHD Transportation Program Manager each month upon completion of the trip.

INVOLUNTARY TREATMENT ACT ADMISSIONS

A sheriff's department, or similar department, with a vehicle that can restrain the patient usually handles involuntary Treatment Admissions. ITA transportation requirements and these providers will not be included under the broker's authority. The provider numbers and billings will be authorized by MAA. Requests for assistance in transporting an ITA patient are to be referred to the local County Designated Mental Health Professional (CDMHP), or local Regional Support Network (RSN).

SUPPORT OF TREATMENT PLANS

Transportation will be authorized for a relative if needed to participate in the client's treatment plan at an inpatient or state hospital, only if verified by MHD Transportation Manager at the MHD. The requesting facility needs to have all information for the broker to contact the MHD Transportation Manager at (360) 902-0822 for an approved Exception Request prior to transport.

B. V. B.

MICA/COD-CLIENTS

All Mentally Ill-Chemical Abuse (MICA) or Co-occurring Disorders (C.O.D.) clients that are Medicaid eligible will be transported in the same manner as an outpatient client to a licensed Mental Health Center only. The licensed Mental Health Center will co-facilitate all MICA/COD therapy with a Mental Health Professional and a Substance Abuse Counselor at a licensed Mental Health Center. Contact the MHD Transportation Manager at (360) 902-0823 if there is any deviation from this policy. **Limited to one round trip per day.** (These trips are billed directly to MAA.)

MENTAL HEALTH DIVISION
TRANSPORTATION EXCEPTION REQUEST

Requester: _____ Date: _____

Consumer Name: _____ Soc. Sec.# _____

Address: _____ PIC# _____

Mental Health Center: _____ Phone: _____

Address: _____ FAX# _____

Contact
Name: _____ Telephone: _____

Reason for the
request: _____

Duration of Exception: _____ Estimated Cost: _____ Actual Cost _____

RETURN TO: MHD Transportation Manager, MHD, P.O. Box 45320, Olympia, WA. 98504
Telephone: (360) 902-0823 FAX: (360) 902-7691/0809

REQUEST APPROVED: <input type="checkbox"/>		D.S.H.S. use only		REQUEST DENIED: <input type="checkbox"/>	
EFFECTIVE DATE					
FROM _____		TO _____		NOT TO EXCEED _____	
M.H.D.					
Approval: _____				Date: _____	
Remarks: _____					

20 REF DOC SUF	TRANS. CODE	M O D	FUND	MASTER INDEX		SUB OBJ	SUB SUB OBJ	ORG INDEX	WORK CLASS	CNTY	CITY/ TOWN	PROJ	SUB PROJ	PROJ PHAS	AMOUNT	INVOICE NUMBER
				APPN INDEX	PROG INDEX											

R V E

**Special Transportation Needs Study
Ray Chisa, Mental Health Administrator
DSHS – Mental Health Division**

INFORMATION

Main population served: Outpatient services for Mentally Ill consumers who are disabled, low income, children (40-50%), and the elderly.

Services are provided at local community mental health clinics for mental health consumers statewide through a Mental Health Managed Care Capitated system contracted through 14 Regional Support Networks under a Federal HCFA waiver. Majority of transportation needs are met through the MAA contracted broker system.

Current transportation usage is 130,000 to 140,000 trips per quarter

TRANSPORTATION SERVICES AND COSTS

The Mental Health Division has no appropriated funds for transportation. Due to limitations and Medicaid restrictions, the Division has provided \$20,000 of state program funds per biennium to cover exceptional situations not covered by the Medicaid system. This program provides pre-approval for gas vouchers or pre-approves direct billing to the division by the MAA broker network for transport on behalf of special situations.

ISSUES. BARRIERS. NEEDS

The Mental Health Division has no appropriated funds for transportation. Mental Health consumers require and need transportation to access education opportunities, employment, training/work programs, shopping, and recreation services to be maintained within their own community.

BARRIERS TO COORDINATION

The uniqueness of various consumer groups and Agency/division constraints and restrictions prevents coordination of services and funding streams. Unique licensing requirements of various agency/divisional provider facilities and networks.

STATE RESPONSIBILITY

Federal and state mandated transportation for a special needs clientele. Legislature is responsible for the provision of special needs transportation to maintain special needs clients within their communities..

2 V 1 E

2

What progress has been made in implementing the ACCT legislation?

ACCT's enabling legislation includes a list of responsibilities that ACCT must fulfill before its sunset in 2008. Chapter 2 reports on the status of each responsibility and includes a table summarizing progress. This provides a clear picture of ACCT's progress, but may overlap content in other parts of the report.

(1) Develop guidelines for local planning of coordinated transportation in accordance with Chapter 47.06B.

A work group of stakeholders developed the Local Planning Guidelines. This group began its

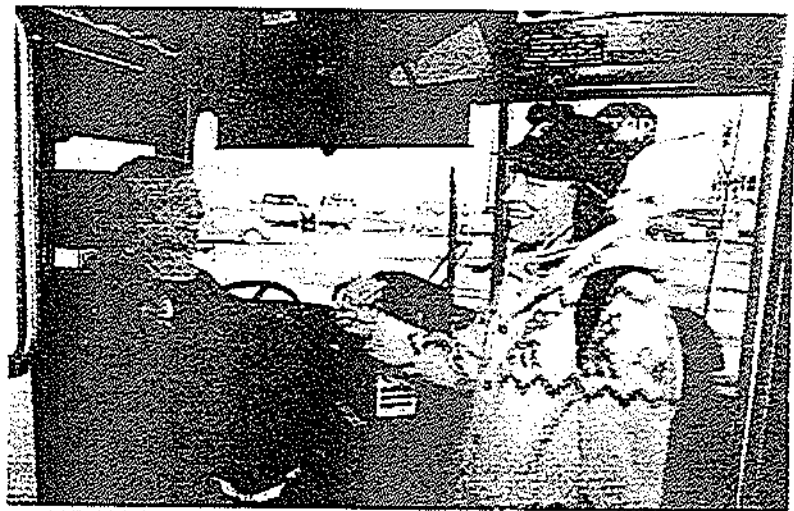
What are the Council's priorities for ACCT?

ACCT has very limited staff support and funding; therefore, the Council prioritized the use of staff time. The Council decided its priorities would be to:

- support local coordination activities and the development of community-based, coordinated transportation systems, and
- seek additional funds to enable ACCT to carry out its full range of responsibilities

What responsibilities must ACCT fulfill?

The statute states that "to assure implementation of the Program for Agency Coordinated Transportation, the Council, in coordination with stakeholders, shall":



Coordinated transportation benefits our communities because it provides for more efficient travel choices.

work in March 1999 and completed it in June 1999. *Local Planning Guidelines* is a comprehensive manual for communities to use when forming local transportation coalitions and designing coordinated systems. These guidelines can be found

sists of representatives from the state agencies that have a stake in special transportation needs. The group meets monthly to address policy and coordination issues. It serves as an advisory body to the Council.

For more information about the PACT Forum, refer to Chapter 3.

- (5) **Provide guidelines for state agencies to use in creating policies, rules, and procedures to encourage the participation of their constituents in community-based planning and coordination, in accordance with this chapter.**

Beginning in December 1999, a work group of the PACT Forum drafted sample guidelines and a process to help state agencies determine if the ACCT legislation applies to them. These were sent to the head of each state agency in September 2000. The document asked each agency to determine whether or not it is affected by the legislation and, if so, to develop coordination guidelines.

The policy guidelines and the agency responses to the survey are detailed in Chapter 3.

- (6) **Facilitate state-level discussion and action on problems and barriers identified by the local forums that can only be resolved at either the state or federal level.**

Communities are able to bring issues to the PACT Forum when

state level action is required.

Work groups have been formed in response to some of those issues. In other cases, ACCT facilitates discussions between state agencies and community providers and stakeholders.



Liz Dunbar, Deputy Secretary of the Department of Social and Health Services, at a recent ACCT meeting.

Chapter 3 provides examples of how ACCT has responded to specific issues raised by communities.

- (7) **Develop and test models for determining the impacts of facility siting and program policy decisions on transportation costs.**

No work has been done to implement this provision.

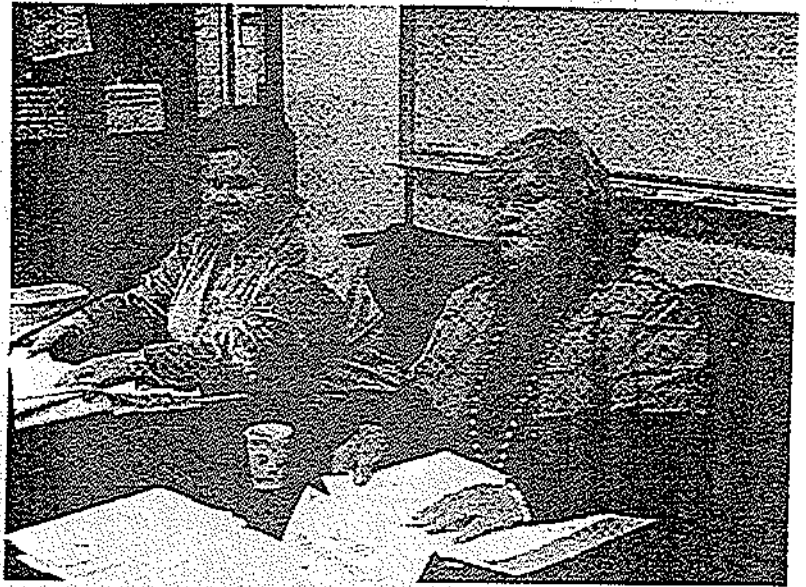
- (12) Develop minimum standards for safety, driver training, and vehicles, and provide models for processes and technology to support coordinated service delivery.**

Minimal activity is taking place regarding this responsibility.

- (13) Provide a clearinghouse for sharing information about transportation coordination best practices and experiences.**

A number of activities are occurring to meet this requirement:

- ACCT created a web site and is developing the site as a mechanism to share information and connect people with resources.
- The local managers of the ACCT grants meet quarterly to share experiences, ideas, and products with each other.
- ACCT maintains a large mailing list and widely distributes meeting minutes and other materials to keep people informed about coordination activities in this state and elsewhere.
- Staff make presentations and conduct workshops at conferences and meetings in order to expand the ACCT network and advance the coordination agenda.



Senator Marilyn Rasmussen, member of the Council, at a recent ACCT meeting. To her left is Marlaina Lieberg, Consumer Representative.

- (14) Promote research and development of methods and tools to improve the performance of transportation coordination in the state.**

Smart cards to allocate costs

ACCT is watching a King County/Metro smart card project that uses a swipe-card and allocation formula to distribute costs when passengers transfer from one transit system to another in the course of a trip. Once implemented, others can use this technology. It can overcome one major barrier to coordination: sharing costs when clients of multiple programs share the same vehicle.

Study is examining need for central point of responsibility

At the urging of advocate groups and legislators who were

(17) Form, convene, and give staff support to stakeholder work groups as needed to continue work on removing barriers to coordinated transportation.

The PACT Forum has formed a number of work groups to address coordination barriers. Additional groups will be formed as problems are identified. PACT Forum members and stakeholders come together in these groups to work on key issues. Chapter 4 describes the major groups that have been formed.

(18) Advocate for the coordination of transportation for people with special transportation needs at the federal, state, and local levels.

ACCT takes its advocacy role seriously, working constantly to ensure that special transportation needs are addressed. Some examples include:

- Reviewing the draft report of the Blue Ribbon Commission on Transportation and sending a letter from the Council to request that coordination and special transportation needs be addressed.
- Funding a study in partnership with the Developmental Disabilities Council to look at how transportation for people with special transportation needs is provided in the state, and to recommend, if deemed necessary, an improved structure for meeting needs.
- Reviewing the coordination guidelines that were issued by the federal Council on Access and Mobility and recommending a more proactive set of coordination guidelines.
- Petitioning the Governor's Office and the legislative finance committees to coordinate the budget process by funding ACCT out of both the state general fund and the multimodal transportation fund.

(19) Recommend to the Legislature changes in laws to assist coordination of transportation services.

For the most part, work has not progressed enough to result in recommendations for changes to law.

However, there is one change in statute that ACCT plans to recommend during the 2001 legislative session. ACCT will recommend that the Legislature adopt a policy statement clarifying that the state does have a role and responsibility for special transportation needs.

(20) Petition the office of financial management to make whatever changes are deemed necessary to identify transportation costs in all executive agency budgets.

Action here depends upon the work of the group that will define transportation costs and develop a mechanism to help track those costs.

Snapshot of progress implementing legislation

Provision	Priority	Status	Activity Level
1. Guidelines for local planning	1st	Done, although a revision is possible	
2. Initiate local planning processes, and 3. Help communities start coalitions	1st	ongoing	high when new funds become available
4. Provide a forum at state level 6. State level discussion and action, and 17. Form work groups to remove barriers 19. Recommend changes to law	1st	ongoing	high
21. Report to the legislature	1 st	biennial	high when report is due
5. State agency coordination guidelines	1 st	first phase is done	high
18. Advocate for coordination	2 nd	ongoing	high
9. Guidelines for evaluating performance, and 10. Develop reporting criteria	3 rd	Foundation laid	minimal
11. Administer grants, and 15. Provide technical assistance, and 16. Support local coalitions	4 th	ongoing	high
7. Models for assessing impacts on transportation	5 th	no progress	none
12. Minimum standards	6 th	little progress	some
8. Identify and track transportation costs	7 th	little progress	some
14. Tools to improve coordination	8 th	some progress	moderate
13. Information clearinghouse	9 th	ongoing	high
20. Petition OFM to make changes	10 th	no progress	none

AGENCY COUNCIL ON COORDINATED TRANSPORTATION

The Agency Council on Coordinated Transportation (ACCT) was created by the legislature in 1998 to promote the coordination of transportation for people with special transportation needs. As defined in statute, (RCW 47.06) this means people "including their personal attendants, who because of physical or mental disability, income status, or age are unable to transport themselves or purchase transportation".

ACCT is structured in the following manner:

- A council of state agencies, transportation providers, consumer advocates, and legislators serves as the decision-making and oversight body.
- The Program for Agency Coordinated Transportation (PACT) Forum consists of representatives from all of the state programs that serve people who have special transportation needs. The PACT Forum carries out the work plan of ACCT and serves as an advisory committee to the council
- Communities select a lead agency to receive a coordination grant and technical assistance from ACCT. With the grant, they form community coalitions to design and implement coordinated transportation systems for people with special transportation needs.

Coordination means that the providers who transport people with transportation needs and health and human service agencies who have clients with special transportation needs work together to improve transportation options and services. Coordination focuses on all aspects of providing transportation, including information, training, vehicles, facilities, call taking, scheduling, dispatching, funding, planning, data collection, maintenance, etc. Through coordination we will use existing resources to best advantage so we can provide more rides. In addition, we will create a process for identifying the needs for additional resources. This will give us an important tool for targeting grants to areas of greatest need, documenting the need for increased funding, and organizing services to better meet the demand for transportation

One important feature of a coordinated community transportation system is single entry process for consumers, so that people seeking transportation options will not have to negotiate multiple systems in order to find the information and service they need.

CURRENT PROGRAMS AND ACTIVITIES **THAT FURTHER THE INTENT OF OLMSTEAD**

ACCT currently provides coordination grants to 21 counties. In the 1999-01 biennium, these counties have been developing special transportation needs community coalitions, conducting community inventories, and exploring different models for coordinated systems. In the next biennium these counties will begin to implement coordinated systems, increasing their capacity to provide rides for people with special transportation needs, and compete for grants.

Once coordinated systems are in place, we expect the following benefits:

- More rides will be provided.
- A single entry process will enable people to easily access information and learn what transportation options are available to them and how to use each option.
- Many communities will use mobility managers to help people solve transportation problems.

Performance Measure

Number of counties implementing a coordinated special transportation needs system:

Develop and implement state agency guidelines

State agencies will complete the development and implementation of broad-based agency policies and guidelines that recognize special transportation needs as a service element needing both top level and field level coordination.

Performance Measure

Number of state agencies adopting coordination policies:

Apply for a grant through the Robert Wood Johnson Foundation

ACCT will apply for a grant specifically to provide transportation for those who would be in institutions without such a service.

Performance Measure

Additional funding sources secured: